

Reg. Dist. No.

VS A15 (4)
15M 9/55

BUREAU V. S.

JAN 16 1957

RECEIVED

00758

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) High Pt.		c. LENGTH OF STAY IN 1b 2 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5900-Osceola Rd.		d. STREET ADDRESS 5900-Osceola Rd.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) THELMA VIRGINIA ADAMSON		4. DATE OF DEATH Month JAN. Day 9 Year 1957	
5. SEX F		6. COLOR OR RACE WHITE	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 11th 1901	
9. AGE (In years lost birthday) 55 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK		10b. KIND OF BUSINESS OR INDUSTRY P.E.P. CO.	
11. BIRTHPLACE (State or foreign country) WASH. D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHARLES T. LYDANE		14. MOTHER'S MAIDEN NAME MAUD V. SEBASTIAN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 577-05-0689	
17. INFORMANT MARY ADAMSON		Address 5900 Osceola Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancerous of left breast DUE TO 170x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Prognosis (c) Metastases DUE TO Metastases PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 6 months 3 months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/8/56 , 19 56 , to 1/10/57 , 19 57 , that I last saw the deceased alive on 1/2/57 , 19 57 , and that death occurred at 8:00 A.M. , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 4147 Corn New Way Dr	
ACTUAL SIGNATURE James A. O'Keefe		DATE SIGNED 1/1/57	
PHYSICIAN'S NAME (Type) James A. O'Keefe M.D.			
22a. BURIAL, CREMATION, or other (Specify) BURIAL		22b. DATE THEREOF JAN. 12, 1957	
22c. NAME OF CEMETERY OR CREMATORY MT. OLIVET		22d. LOCATION (City, town, or county) (State) WASH. D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Limby Vanlon		24a. REC'D BY REGISTRAR 1/1/57	
ADDRESS 3831-GA. Ave. N.W.		24b. REGISTRAR'S SIGNATURE H. H. Hedrich	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO VITAL REGISTRAR: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

RECEIVED

may be retained by the hospital or attending physician. TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00759

CERTIFICATE OF DEATH

Reg. Dist. No. 215

791

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Mont.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>				c. LENGTH OF STAY IN 1b <u>6 1/2</u> Hours			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Bethesda, Md.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. STREET ADDRESS <u>5811 Kingswood Road</u>							
3. NAME OF DECEASED (Type or print) First <u>Benjamin</u> Middle <u>Barnwell</u> Last <u>AIKEN</u>				4. DATE OF DEATH Month <u>January</u> Day <u>10</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Cauc</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-22-1893</u>	
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. Navy</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Navy</u>	
11. BIRTHPLACE (State or foreign country) <u>South Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>					
13. FATHER'S NAME <u>Wyatt AIKEN</u>				14. MOTHER'S MAIDEN NAME <u>Mary BARNWELL</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WW1</u> <u>WW2</u> <u>None</u>				17. INFORMANT <u>(Wife) Charlotte AIKEN (Same as #2)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>aneurism, aorta, dissecting</u> DUE TO <u>451 X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerosis, aorta</u> DUE TO <u>Hypertensive Vascular Disease</u> (c) <u> </u>				INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs.</u> <u>Indef.</u> <u>Indef.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>10 January</u> , <u>1957</u> , to <u>10 January</u> , <u>1957</u> , that I last saw the deceased alive on <u>10 January</u> , <u>1957</u> , and that death occurred at <u>2130 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>H. E. Richardson</u>				M.D. <u>U.S. Naval Hospital, Bethesda, Md.</u> <u>1-11-57</u>			
PHYSICIAN'S NAME (Type) <u>H. E. RICHARDSON, CAPT, MC, USN</u>				<u>U.S. Naval Hospital, Bethesda, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-15-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat. Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H.A. Pumphrey</u>				ADDRESS <u>7557 Wisconsin Ave. Bethesda, Md.</u>		24a. REC'D BY REGISTRAR <u> </u> 24b. REGISTRAR'S SIGNATURE <u> </u>	
DATE <u>1-11-57</u>							

CERTIFICATE OF DEATH

WESTLAND STATE DEPARTMENT OF HEALTH - BATHING 18

NAME OF DECEASED		DATE OF DEATH	
JAMES H. HARRIS		JAN 14 1957	
AGE		SEX	
65		M	
RACE		OCCUPATION	
W		RETIRED	
BIRTH DATE		BIRTH PLACE	
JAN 14 1892		NEW YORK	
MARRIAGE DATE		MARRIAGE PLACE	
JAN 14 1915		NEW YORK	
PREVIOUS MARRIAGES		PREVIOUS MARRIAGES	
NONE		NONE	
CAUSE OF DEATH		MANNER OF DEATH	
HEART DISEASE		NATURAL	
IMMEDIATE CAUSE		MANNER OF DEATH	
HEART DISEASE		NATURAL	
UNDERLYING CAUSE		MANNER OF DEATH	
HEART DISEASE		NATURAL	
PLACE OF DEATH		PLACE OF DEATH	
HOME		HOME	
DATE OF DEATH		DATE OF DEATH	
JAN 14 1957		JAN 14 1957	
SIGNATURE OF DECEASED		SIGNATURE OF DECEASED	
JAMES H. HARRIS		JAMES H. HARRIS	
DATE OF SIGNATURE		DATE OF SIGNATURE	
JAN 14 1957		JAN 14 1957	
SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
JAMES H. HARRIS		JAMES H. HARRIS	
DATE OF SIGNATURE		DATE OF SIGNATURE	
JAN 14 1957		JAN 14 1957	
SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN	
JAMES H. HARRIS		JAMES H. HARRIS	
DATE OF SIGNATURE		DATE OF SIGNATURE	
JAN 14 1957		JAN 14 1957	

BUREAU V. S.

JAN 14 1957

RECEIVED

795

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 SILVER SPRING	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 416 East Melbourne Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First GRACE Middle ELLEN Last ALLNUT		4. DATE OF DEATH Month JAN. Day 23 Year 19 57	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/9/93
9. AGE (In years last birthday) yrs. 63		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MONTG. COUNTY SCHOOL PATROL WOMAN		10b. KIND OF BUSINESS OR INDUSTRY MARYLAND	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM A. JACKSON		14. MOTHER'S MAIDEN NAME MAGGIE E. PARSLEY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NO	
17. INFORMANT Miss Florence Jackson, 416 East Melbourne Ave. Silver Spring, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of uterus & metastasis 174X DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertension INTERVAL BETWEEN ONSET AND DEATH about 18 mo.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1952 to 23 Jan , 19 57 , that I last saw the deceased alive on 23 Jan , 19 57 , and that death occurred at 11 A M. from the causes and on the date stated above.			
ACTUAL SIGNATURE William D. Aud		ADDRESS (Street, city or town, state) 906 Columbia Rd, Silver Spring, Md	
PHYSICIAN'S NAME (Type) WILLIAM D. AUD		DATE SIGNED 1/24/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1/26/57	
22c. NAME OF CEMETERY OR CREMATORY MOUNT TABOR		22d. LOCATION (City, town, or county) (State) ETHISON, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey		24a. REC'D BY REGISTRAR 1/28/57	
ADDRESS SILVER SPRING, MD.		24b. REGISTRAR'S SIGNATURE Francis Potter	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. CAUSE OF DEATH		8. MANNER OF DEATH	
JAMES EARL RAY		M		35		APR 22 1928		MOBILE, ALABAMA		COUNSELLOR		HEART DISEASE		NATURAL	
9. DATE OF DEATH		10. PLACE OF DEATH		11. TIME OF DEATH		12. SIGNATURE OF PHYSICIAN		13. SIGNATURE OF MINISTER		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY		16. SIGNATURE OF DECEASED	
APR 4 1968		MEMPHIS, TENNESSEE		10:15 AM		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
17. NAME OF FUNERAL HOME		18. NAME OF BURIAL PLACE		19. NAME OF CEMETERY		20. NAME OF CHURCH		21. NAME OF MINISTERS		22. NAME OF CORONER		23. NAME OF JURY		24. NAME OF DECEASED	
[Blank]		[Blank]		[Blank]		[Blank]		[Blank]		[Blank]		[Blank]		[Blank]	

BUREAU V. S.

FEB 1 1967

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00761

Reg. Dist. No.

213

<p style="font-size: 1.5em; margin: 0;">796</p>							
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Derwood RFD				c. LENGTH OF STAY IN 1b 6 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 26 Rockville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Russell Nurseing Home				d. STREET ADDRESS 1 Lincoln Park		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle Arnold Last				4. DATE OF DEATH Month Jan. Day 20, Year 1957			
5. SEX male	6. COLOR OR RACE col.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 4, 1900		9. AGE (In years last birthday) 56 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME James Arnold				14. MOTHER'S MAIDEN NAME Lizy H unter			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT John Arnold		Address Germantown, Md.	
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vasoylear Accident 331X DUE TO Hypertention Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)</p>						<p>INTERVAL BETWEEN ONSET AND DEATH 25 days</p>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>Frank J. Broschart</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) Frank J. Broschart				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Jan. 20, 1957	
22a. BURIAL, CREMATION, or other disposition (Specify)		22b. DATE THEREOF 1/24/57		22c. NAME OF CEMETERY OR CREMATORY Lincoln Park,		22d. LOCATION (City, town, or county) (State) Rockville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert L. Swander</i>				ADDRESS Rockville, Md.		24a. REC'D BY REGISTRAR DATE 28 1957	
				24b. REGISTRAR'S SIGNATURE <i>Laurell Taylor</i>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF MARYLAND
DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race		Date of Death		Place of Death	
James Arnold		39		Male		White		Jan. 20, 1957		Lincoln Park	
Residence		Occupation		Cause of Death		Manner of Death		Time of Death		Signature of Examiner	
Lincoln Park		Police Officer		Heart Disease		Natural		10:30 AM		J. H. Smith	
City of Baltimore		Baltimore, Md.		County of Baltimore		State of Maryland		Date of Report		Signature of Coroner	
Baltimore, Md.		Baltimore, Md.		Baltimore, Md.		Baltimore, Md.		Baltimore, Md.		Baltimore, Md.	

BUREAU V. S.

JAN 29 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00762
Reg. Dist. No. 212

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Poolesville</u> c. LENGTH OF STAY IN 1b <u>D.O.A.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Edward Froy - Potomac R.</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Poolesville</u> d. STREET ADDRESS <u>/</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Grace</u> First <u>Stearns</u> Middle <u>Grace</u> Last <u>And</u>		4. DATE OF DEATH Month <u>Jan</u> Day <u>9</u> Year <u>1957</u>		5. SEX <u>Female</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>7-22-23</u> 9. AGE (In years last birthday) <u>33</u> yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>md</u> 11. BIRTHPLACE (State or foreign country) <u>md</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Charles Stearns</u> 14. MOTHER'S MAIDEN NAME <u>Grace Keetch</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>519-15-47-90</u> 17. INFORMANT <u>J. R. Boyd - Washington 20, DC</u> Address <u>dc</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> <u>975x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>drowning</u> DUE TO (c) <u>/</u> </p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>/</u></p> </div> <div style="width: 15%; text-align: center;"> INTERVAL BETWEEN ONSET AND DEATH <u>Found dead in Pot R.</u> </div> </div>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>11</u> a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D. EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>Jan 9 - 57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>1/11/57</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Monocacy</u> 22d. LOCATION (City, town, or county) (State) <u>Beallsville md</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>William B. Holton</u> ADDRESS <u>Bremerville md</u> 24. REC'D BY REGISTRAR <u>1/10/57</u> 24b. REGISTRAR'S SIGNATURE <u>Charles W. Elgin</u>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for the files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF MARYLAND
DEPARTMENT OF HEALTH - BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

JAN 14 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, or other person authorized by the law, should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00763

798

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		d. STREET ADDRESS 4301 Massachusetts Ave NW	
3. NAME OF DECEASED (Type or print) First JOSEPH Middle BAILEY Last BAILEY		4. DATE OF DEATH Month January Day 14 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 4, 1856
9. AGE (In years last birthday) yrs. 100		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Real Estate	
11. BIRTHPLACE (State or foreign country) London, England		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME (?) Bailey		14. MOTHER'S MAIDEN NAME Charlotte (?)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 4801 Mass. Ave NW	
17. INFORMANT Mrs Lucile Hartmeyer Washington, DC		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart Failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 1 mo	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-19 , 19 56 , to 1-14 , 19 57 , that I last saw the deceased alive on 1-13 , 19 57 , and that death occurred at 6:4 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Joseph A. Bailey M.D. Wardman Clinic 1-18-57 PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/14/57	
22c. NAME OF CEMETERY OR CREMATORY Prairie Home Cemetery		22d. LOCATION (City, town, or county) (State) Waukesha Wisconsin	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Gawlik Sons		24a. REC'D BY REGISTRAR 1-18-57	
24b. REGISTRAR'S SIGNATURE Bessie M. Thompson			

CERTIFICATE OF DEATH

Set 6/1/19

Name of Deceased		Age		Sex		Race		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
John Doe		45		Male		White		Jan 1, 1910		London, England		123 Main St, Baltimore, MD		Heart Disease		Jan 15, 1957		10:00 AM		Home		[Signature]		[Signature]	
Occupation		Education		Marital Status		Religion		Last Illness		Previous Illnesses		Alcohol Consumption		Tobacco Use		Mental Condition		Social History		Family History		Other Notes			
Teacher		High School		Married		Catholic		2 weeks		None		Occasional		Daily		Normal		None		None		None			
Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Date of Death		Time of Death		Place of Death	
Jan 15, 1957		10:00 AM		Home		[Signature]		[Signature]		Jan 15, 1957		10:00 AM		Home		[Signature]		[Signature]		Jan 15, 1957		10:00 AM		Home	

BUREAU V. 2

JAN 21 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 Item 8 Film G209 1-21-57 et
 799
 CERTIFICATE OF DEATH

00764
 217

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney				c. LENGTH OF STAY IN 1b 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital, Inc.				d. STREET ADDRESS 406 Monroe Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ella Middle Barkley Last Barkley				4. DATE OF DEATH Month January Day 6 Year 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/7/9998	
9. AGE (In years last birthday) 58 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Richard E. Parsley		14. MOTHER'S MAIDEN NAME BARBARA J. Wilson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 111-11-1111		17. INFORMANT Hospital Record			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intra-Cranial Hemorrhage 443x DUE TO left cerebral Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive - Cardio-Vascular DUE TO Cerebral (c) Arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH 2 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 4 , 19 57 , to Jan. 6 , 19 57 , that I last saw the deceased alive on Jan. 6 , 19 57 , and that death occurred at 9 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Jack Schumacher		ADDRESS (Street, city or town, state) 26 N. Summit Ave., Gaithersburg, Md.					
PHYSICIAN'S NAME (Type) Jack Schumacher, M. D.		DATE SIGNED 1-6-57					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan 9, 57		22c. NAME OF CEMETERY OR CREMATORY Salem		22d. LOCATION (City, town, or county) (State) Cedar Grove Md	
23. FUNERAL DIRECTOR'S SIGNATURE Roy W Barber				ADDRESS Raytonville Md		24a. REC'D BY REGISTRAR DATE 1-10-57	
				24b. REGISTRAR'S SIGNATURE Bertina B Lantz			

5/5

BUREAU V. S.

JAN 16 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 14 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

800

CERTIFICATE OF DEATH

00765

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington, Md</u>		c. LENGTH OF STAY IN 1b <u>11 mos</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase X2</u>		d. STREET ADDRESS <u>3113 Winnett Rd</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Gardens Sanitarium</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Fannie</u> Middle <u>G</u> Last <u>Bell</u>		4. DATE OF DEATH Month <u>Jan</u> Day <u>26</u> Year <u>19 57</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jul 18, 1871</u>
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>8</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Judge Alexander J Brand</u>	
14. MOTHER'S MAIDEN NAME <u>Fannie Glenn Stewart</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unknown</u>	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. E. R. Clark, 3113 Winnett Rd. Ch. Ch</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction</u> DUE TO <u>420.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary occlusion</u> (c) <u>arteriosclerotic Heart Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6th</u> <u>6th</u> <u>2+yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>a. m.</u> <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>23 Feb 48</u> to <u>26 JAN 57</u> , that I last saw the deceased alive on <u>26 JAN 56</u> , and that death occurred at <u>7 a. m.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A. H. RICHWINE</u> M.D.		ADDRESS (Street, city or town, state) <u>5522 Western Ave 26</u>	
DATE SIGNED <u>JAN 57</u>		PHYSICIAN'S NAME (Type) <u>A. H. RICHWINE - Ch Ch 15, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/29/1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Marys, Rockville</u>		22d. LOCATION (City, town, or county) (State) <u>Montgomery Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Bethesda, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE 1-28-57</u>	
24b. REGISTRAR'S SIGNATURE <u>Bernie M. Thompson</u>			

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
MAGGIE J. HARRIS		61		F		W		JAN 10 1896		BALTIMORE, MD	
MARRIAGE		DATE OF MARRIAGE		PLACE OF MARRIAGE		NAME OF SPOUSE		DATE OF DEATH		PLACE OF DEATH	
MARRIED		JAN 10 1915		BALTIMORE, MD		W. H. HARRIS		JAN 10 1957		BALTIMORE, MD	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		SCHOOLING	
HEART DISEASE		NATURAL		HOUSEWIFE		HIGH SCHOOL		METHODIST		12	
SIGNS AND SYMPTOMS		PREVIOUS ILLNESS		PREVIOUS SURGERY		PREVIOUS TRAUMA		PREVIOUS DRUGS		PREVIOUS ACCIDENTS	
PAIN		FEBRUARY 1957		JANUARY 1957		NO		NO		NO	
TEMPERATURE		101.0		100.0		98.6		98.6		98.6	
PULSE		100		90		80		80		80	
BLOOD PRESSURE		120/80		110/70		100/60		100/60		100/60	
RESPIRATION		20		18		16		16		16	
URINE		NORMAL		NORMAL		NORMAL		NORMAL		NORMAL	
FECES		NORMAL		NORMAL		NORMAL		NORMAL		NORMAL	
SPEECH		NORMAL		NORMAL		NORMAL		NORMAL		NORMAL	
MIND		NORMAL		NORMAL		NORMAL		NORMAL		NORMAL	
MOOD		NORMAL		NORMAL		NORMAL		NORMAL		NORMAL	
BEHAVIOR		NORMAL		NORMAL		NORMAL		NORMAL		NORMAL	
GENERAL APPEARANCE		NORMAL		NORMAL		NORMAL		NORMAL		NORMAL	
SKIN		NORMAL		NORMAL		NORMAL		NORMAL		NORMAL	
EYES		NORMAL		NORMAL		NORMAL		NORMAL		NORMAL	
EARS		NORMAL		NORMAL		NORMAL		NORMAL		NORMAL	
NOSE		NORMAL		NORMAL		NORMAL		NORMAL		NORMAL	
MOUTH		NORMAL		NORMAL		NORMAL		NORMAL		NORMAL	
THROAT		NORMAL		NORMAL		NORMAL		NORMAL		NORMAL	
LUNGS		NORMAL		NORMAL		NORMAL		NORMAL		NORMAL	
HEART		NORMAL		NORMAL		NORMAL		NORMAL		NORMAL	
LIVER		NORMAL		NORMAL		NORMAL		NORMAL		NORMAL	
SPLEEN		NORMAL		NORMAL		NORMAL		NORMAL		NORMAL	
PANCREAS		NORMAL		NORMAL		NORMAL		NORMAL		NORMAL	
GASTROINTESTINAL		NORMAL		NORMAL		NORMAL		NORMAL		NORMAL	
UROGENITAL		NORMAL		NORMAL		NORMAL		NORMAL		NORMAL	
ENDOCRINE		NORMAL		NORMAL		NORMAL		NORMAL		NORMAL	
IMMUNE		NORMAL		NORMAL		NORMAL		NORMAL		NORMAL	
REPRODUCTIVE		NORMAL		NORMAL		NORMAL		NORMAL		NORMAL	
OTHER		NORMAL		NORMAL		NORMAL		NORMAL		NORMAL	

Magdalena Harris
 General practitioner
 211 N. ...
 211 N. ...
 211 N. ...

RECEIVED
 JAN 30 1957
 BUREAU V. R.
 A.H. RICHMOND
 225 ...
 26 JAN 26 ...

801

CERTIFICATE OF DEATH

00766

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY District of Columbia			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 2mos. 14 days			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3				d. STREET ADDRESS 4501 44th St., N.W.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Maryland				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Louis Middle Albert Last BICKERTON				4. DATE OF DEATH Month January Day 14 Year 19 57			
5. SEX Male		6. COLOR OR RACE Cauc.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 23 December 1900	
9. AGE (In years last birthday) 56		IF UNDER 1 YEAR Months 56 Days 56		IF UNDER 24 HRS. Hours 56 Min. 56			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Antique Shop				10b. KIND OF BUSINESS OR INDUSTRY Self-employed		11. BIRTHPLACE (State or foreign country) District of Columbia	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME Harry Bickerton				14. MOTHER'S MAIDEN NAME Landonia Scroggins			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. Unknown		17. INFORMANT (Wife) Mrs. Ray D. Bickerton (Same As #2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 162X Bronchogenic carcinoma DUE TO (b) 6 mos. DUE TO (c) 6 mos. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.				INTERVAL BETWEEN ONSET AND DEATH 6 mos.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 410X Rheumatic Heart Disease & Mitral Stenosis				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 31 Oct. , 19 56 , to 14 Jan. , 19 57 , that I last saw the deceased alive on 14 Jan. , 19 57 , and that death occurred at 3:50 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 1-15-57							
ACTUAL SIGNATURE J. T. Horgan				PHYSICIAN'S NAME (Type) J. T. HORGAN, LT, MC, USN			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 1-17-57		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery	
22d. LOCATION (City, town, or county) (State) Arlington, Virginia							
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey				ADDRESS Bethesda, Md.		24a. REC'D BY REGISTRAR 1-15-57	
24b. REGISTRAR'S SIGNATURE Mary E. Cassel							

MEDICAL CERTIFICATION

2

51

1

M

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4

may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely in by the funeral director, the registrar should be detached for use as the burial-transit permit. Pages 1 and 2 should be kept with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

URGENT

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

NAME OF DECEASED U.S. Naval Reserve, Baltimore, Maryland		DATE OF DEATH January 17, 1957	
RESIDENCE 1201 West 20th St., N.E.		PLACE OF DEATH Home	
MARRIAGE Married		CAUSE OF DEATH Heart Disease	
DATE OF BIRTH January 17, 1900		PLACE OF BIRTH District of Columbia	
OCCUPATION Self-employed		EDUCATION High School	
MILITARY SERVICE U.S. Naval Reserve		RELIGION Roman Catholic	
PREVIOUS ILLNESS None		TREATMENT None	
SIGNATURE OF DECEASED (None)		SIGNATURE OF WITNESSES (None)	
SIGNATURE OF PHYSICIAN (None)		SIGNATURE OF REGISTRAR (None)	

BUREAU V. R.

JAN 17 1957

RECEIVED

802

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH o. COUNTY MONTGOMERY COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL-NEAR ASHTON, MD.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON, D.C. 47x3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MERILEA NURSING HOME -14511 COLESVILLE ROAD				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Bessie Rice Blackwell				4. DATE OF DEATH Month Day Year Jan 10 1957			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-1-1856	
9. AGE (In years lost birthday) 100 yrs.		IF UNDER 1 YEAR Months 2 Days 9 Hours Min. 		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE --- RETIRED				10b. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE		11. BIRTHPLACE (State or foreign country) FREDERICKSBURG, VA.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME ROBERT E. SMITH				14. MOTHER'S MAIDEN NAME MARY JANE HOOE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT (Attorney) Address MR. GRIMES 413 N. BEND ROAD, BALTIMORE, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 501x Bronchial pneumonia DUE TO (b) Veins - bronchitis DUE TO (c) — Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
INTERVAL BETWEEN ONSET AND DEATH 1 day 2 1/2 days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 422.2 Chronic myocardial disease							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 7-3 , 19 55 , to 1-10 , 19 57 , that I last saw the deceased alive on 1-9 , 19 57 , and that death occurred at 6:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED John S. Rogers M.D. 1917 Seminary Rd. Silver Spring Md. 12057							
ACTUAL SIGNATURE							
PHYSICIAN'S NAME (Type) John S. Rogers M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1-12-57		22c. NAME OF CEMETERY OR CREMATORY THE CITY CEMETERY		22d. LOCATION (City, town, or county) (State) FREDERICKSBURG, VIRGINIA	
23. FUNERAL DIRECTOR'S SIGNATURE MARTIN W. HYSOONG COMPANY INC. 1300 N. STREET, NORTHWEST WASHINGTON, 5, D.C.				24a. REC'D BY REGISTRAR 1957		24b. REGISTRAR'S SIGNATURE Gertrude Lawler	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. in by the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD

DATE OF DEATH

MARYLAND

WATKINS COUNTY

DECEASED'S NAME (Last, first, middle)

DATE OF BIRTH

SEX

EDUCATION

RELIGION

OCCUPATION

CAUSE OF DEATH (Immediate)

DATE OF DEATH

PLACE OF DEATH

DECEASED'S RESIDENCE

DECEASED'S OCCUPATION

BUREAU V. 2

JAN 14 1957

RECEIVED

803

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE District of Columbia by COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 2 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3			
f. STREET ADDRESS 7 Armour Green S.W.				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Joseph Middle John Last BLECLIC				4. DATE OF DEATH Month January Day 18 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 17 January 1957	9. AGE (In years last birthday) 00 yrs.	IF UNDER 1 YEAR Months 00 Days 02	IF UNDER 24 HRS. Hours 00 Min. 00	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) - - -		10b. KIND OF BUSINESS OR INDUSTRY - - -		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John P. BLECLIC				14. MOTHER'S MAIDEN NAME Grace A. MOORE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. - - - - -		17. INFORMANT (Father) John P. BLECLIC		Address same as 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 760.0 CENTRAL NERVOUS SYSTEM DAMAGE RESPIRATORY EMBARRASSMENT DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) SUB ARACHNOID HEMORRHAGE DUE TO (c) 23 Hours							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. 19 p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from 17 Jan , 19 57 , to 18 Jan , 19 57 , that I last saw the deceased alive on 18 Jan , 19 57 , and that death occurred at 1035P M, from the causes and on the date stated above.							
ACTUAL SIGNATURE D. Shuptar			ADDRESS (Street, city or town, state)		DATE SIGNED		
PHYSICIAN'S NAME (Type) D. SHUPTAR LTCMC USN			M.D. U. S. Naval Hospital, Bethesda Md 1-19-57				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-23-57	22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia		
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Humphrey, 7557 Wisconsin Ave., Bethesda Md.			24a. REC'D BY REGISTRAR DATE 1-18-57		24b. REGISTRAR'S SIGNATURE <i>May E. Russell</i>		

2051273XV5

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, the page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

Name (Last, First, Middle)		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
John P. ...		Male		...		...		...		...		...		...		...		...		...		...
Occupation		Education		Marital Status		Previous Illnesses		Previous Injuries		Previous Operations		Previous Habits		Previous Occupations		Previous Residences		Previous Deaths		Previous Burials		Previous Cremations	
...		
Signature of Physician		Signature of Registrar		Signature of Coroner		Signature of Medical Examiner		Signature of Pathologist		Signature of Toxicologist		Signature of Forensic Scientist		Signature of Forensic Anthropologist		Signature of Forensic Entomologist		Signature of Forensic Microscopist		Signature of Forensic Chemist		Signature of Forensic Biologist	
...		

RECEIVED
JAN 23 1957
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, or other person authorized by the law, should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00769

804

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Virginia b. COUNTY Quantico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Quantico	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		d. STREET ADDRESS #4 Weaver Road, Fuller Hgts.	
3. NAME OF DECEASED (Type or print) First Ruth Middle Ellen Last BOGERT		4. DATE OF DEATH Month January Day 23 Year 19 57	
5. SEX Female	6. COLOR OR RACE Cauc.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 15 April 1949
9. AGE (In years lost birthday) yrs. 7		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John Marshal Bogert		14. MOTHER'S MAIDEN NAME Ruth Coleman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT (Father) John M. Bogert (Same As #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Lymphatic Leukemia 2040 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 28 months			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. p. _____ p. m. _____ Month _____ Day _____ Year 19 57		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from 11 January, 19 57 , to 23 January, 19 59 , that I last saw the deceased alive on January 23, 19 57 , and that death occurred at 09:55A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE George J. A. Magnant M.D. U.S. Naval Hospital, Bethesda, Md. 1-23-57 PHYSICIAN'S NAME (Type) George J.A. Magnant, LT, MC, USN U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-28-57	
22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Hall Funeral Home, Occoquan, Virginia		24a. REC'D BY REGISTRAR DATE 1-23-57	
24b. REGISTRAR'S SIGNATURE Ray E. Russell			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

BUREAU V. E.

1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

00770
223

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>56 Silver Spring</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanitarium + Hosp</i>		d. STREET ADDRESS <i>1709 Midland Road</i>	
3. NAME OF DECEASED (Type or print) First <i>Catherine</i> Middle <i>Regina</i> Last <i>Bontz</i>		4. DATE OF DEATH Month <i>1</i> Day <i>20</i> Year <i>1957</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Cauc.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6-24-91</i>
9. AGE (In years last birthday) <i>65</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>OWN HOME</i>	
11. BIRTHPLACE (State or foreign country) <i>Illinois</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>SAMPERTON Edward</i>		14. MOTHER'S MAIDEN NAME <i>Margaret E. Kane</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>579-10-0803-A</i>	
17. INFORMANT <i>Old Record + patient.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Congestive Heart Failure</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>chronic thrombosis + chr Myocarditis</i> DUE TO <i>Arteriosclerosis</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Chronic Bronchopneumitis + Hemiparesis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i> <i>2 yrs.</i> <i>15 yrs</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <i>Ischemic Disease</i>	
20c. TIME OF INJURY Month, Day, Year Hour <i>a.m.</i> <i>19</i>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>May 25, 1938</i> to <i>Jan 20, 1957</i> , that I last saw the deceased alive on <i>Jan 30, 1957</i> , and that death occurred at <i>1709 Midland Road</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Kenneth F. Laughlin</i> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <i>934 Ellsworth Dr. 1-20-57</i>	
PHYSICIAN'S NAME (Type) <i>KENNETH F. LAUGHLIN</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	22b. DATE THEREOF <i>1/23/57</i>	22c. NAME OF CEMETERY OR CREMATORY <i>MT. OLIVET CEMETERY</i>	22d. LOCATION (City, town, or county) (State) <i>WASHINGTON, D.C.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Warner E. Humphrey</i>		24. REC'D BY REGISTRAR <i>J. Edgar Dodd</i>	
24b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Use Only in

<p>1. NAME OF DECEASED [Faint handwritten name]</p>		<p>2. SEX [Faint handwritten sex]</p>	
<p>3. AGE [Faint handwritten age]</p>		<p>4. DATE OF BIRTH [Faint handwritten date]</p>	
<p>5. PLACE OF BIRTH [Faint handwritten place]</p>		<p>6. OCCUPATION [Faint handwritten occupation]</p>	
<p>7. MARITAL STATUS [Faint handwritten status]</p>		<p>8. CAUSE OF DEATH [Faint handwritten cause]</p>	
<p>9. MEDICAL HISTORY [Faint handwritten history]</p>		<p>10. SIGNATURE OF PHYSICIAN [Faint handwritten signature]</p>	
<p>11. SIGNATURE OF WITNESS [Faint handwritten signature]</p>		<p>12. DATE OF DEATH [Faint handwritten date]</p>	
<p>13. PLACE OF DEATH [Faint handwritten place]</p>		<p>14. SIGNATURE OF REGISTRAR [Faint handwritten signature]</p>	

BUREAU V. 5

Jan 28 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

805

CERTIFICATE OF DEATH

00771

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)			c. LENGTH OF STAY IN 1b 1 day		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Maryland			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Francis Middle Wheatley Last BORDEN			4. DATE OF DEATH Month January Day 21 Year 57		
5. SEX Female	6. COLOR OR RACE Cauc.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-10-1869	9. AGE (In years last birthday) yrs. 86	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Dist. of Columbia	
13. FATHER'S NAME Samuel E. Wheatley		12. CITIZEN OF WHAT COUNTRY? U.S.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT (Son) Sam W. Borden, Gibson Island, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Peritonitis, acute 570.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Gangrenous, small bowel loop DUE TO (c) Small bowel obstruction, adhesions 3 days.					INTERVAL BETWEEN ONSET AND DEATH Less than 24 hr.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary Edema, Cardiac failure.					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (County) (State)	
21. I certify that I attended the deceased from 20 January, 19 57 to 21 January, 19 57 , that I last saw the deceased alive on 21 January, 19 57 , and that death occurred at 09:00A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Bert C. Johnson M.D. U.S. Naval Hospital, Bethesda Md. 1-22-57 ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) Bert C. Johnson, LCDR, MC, USN U.S. Naval Hospital, Bethesda, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-25-57		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery	
22d. LOCATION (City, town, or county) Arlington, Virginia		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE James Paul's Sons Cawler's, 1756 Pennsylvania Ave., Washington, D.C.		24a. REC'D BY REGISTRAR 1-22-57		24b. REGISTRAR'S SIGNATURE Frank E. Parrelly	

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES H. HARRIS		M		45		1912		BALTIMORE		MD		MD		USA	
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY	
LABORER		HEART DISEASE		NATURAL		JAN 24 1957		BALTIMORE		MD		MD		USA	
EDUCATION		RELIGION		MARITAL STATUS		DATE OF MARRIAGE		PLACE OF MARRIAGE		CITY		STATE		COUNTRY	
HIGH SCHOOL		METHODIST		MARRIED		1935		BALTIMORE		MD		MD		USA	
FATHER'S NAME		MOTHER'S NAME		DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY			
JAMES H. HARRIS		MARY H. HARRIS		JAN 24 1957		BALTIMORE		MD		MD		USA			
FATHER'S OCCUPATION		MOTHER'S OCCUPATION		DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY			
LABORER		LABORER		JAN 24 1957		BALTIMORE		MD		MD		USA			
FATHER'S DATE OF BIRTH		MOTHER'S DATE OF BIRTH		DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY			
1912		1912		JAN 24 1957		BALTIMORE		MD		MD		USA			
FATHER'S PLACE OF BIRTH		MOTHER'S PLACE OF BIRTH		DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY			
BALTIMORE		BALTIMORE		JAN 24 1957		BALTIMORE		MD		MD		USA			
FATHER'S STATE		MOTHER'S STATE		DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY			
MD		MD		JAN 24 1957		BALTIMORE		MD		MD		USA			
FATHER'S COUNTRY		MOTHER'S COUNTRY		DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY			
USA		USA		JAN 24 1957		BALTIMORE		MD		MD		USA			

BUREAU V. 3

JAN 24 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

223

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park c. LENGTH OF STAY IN 1b 39 Hrs.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY District of Columbia 47X-3				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium & Hospital				d. STREET ADDRESS 4630 30th Street N.W.				
3. NAME OF DECEASED (Type or print) Maude Agnes Bowman				4. DATE OF DEATH Month January Day 16 Year 1957				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH II-I-89		
9. AGE (In years last birthday) 67		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? America		
13. FATHER'S NAME Joseph T. Wade				14. MOTHER'S MAIDEN NAME Rose Abrams				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) None		16. SOCIAL SECURITY NO. -----		17. INFORMANT Hospital Records				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure 193X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral edema DUE TO Glioblastoma multiforme (c) right frontal lobe							INTERVAL BETWEEN ONSET AND DEATH 6 hours 4 weeks 6 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----						
20c. TIME OF INJURY Hour 19 Month 19 Day 19 Year 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from May 6, 1946 to Jan 16, 1957 , that I last saw the deceased alive on 1-16-57 , 19 57 , and that death occurred at 3:30 M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) 934 Ellsworth Dr. 1-16-57 DATE SIGNED -----								
ACTUAL SIGNATURE Kenneth F. Laughlin		M.D. -----						
PHYSICIAN'S NAME (Type) Kenneth F. Laughlin		-----						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-19-57		22c. NAME OF CEMETERY OR CREMATORY Natchez		22d. LOCATION (City, town, or county) (State) Washington, D.C.		
23. FUNERAL DIRECTOR'S SIGNATURE Deal Funeral Home				ADDRESS 4812 Ga Avenue		24a. REC'D BY REGISTRAR DATE 1/19/57		
				24b. REGISTRAR'S SIGNATURE -----				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

Page No. 10

<p>1. NAME OF DECEASED [Illegible]</p>		<p>2. SEX [Illegible]</p>	
<p>3. AGE [Illegible]</p>		<p>4. DATE OF BIRTH [Illegible]</p>	
<p>5. PLACE OF BIRTH [Illegible]</p>		<p>6. OCCUPATION [Illegible]</p>	
<p>7. MARITAL STATUS [Illegible]</p>		<p>8. COLOR [Illegible]</p>	
<p>9. CAUSE OF DEATH [Illegible]</p>		<p>10. MANNER OF DEATH [Illegible]</p>	
<p>11. PLACE OF DEATH [Illegible]</p>		<p>12. DATE OF DEATH [Illegible]</p>	
<p>13. SIGNATURE OF DECEASED [Illegible]</p>		<p>14. SIGNATURE OF WITNESS [Illegible]</p>	
<p>15. SIGNATURE OF PHYSICIAN [Illegible]</p>		<p>16. SIGNATURE OF CORONER [Illegible]</p>	
<p>17. SIGNATURE OF JUDGE [Illegible]</p>		<p>18. SIGNATURE OF CLERK [Illegible]</p>	

BUREAU V. 5

JAN 21 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00773

806

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 70 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 47x3 Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center National Institutes of Health, Bethesda, Md.				d. STREET ADDRESS 6606 Georgia Avenue, N.W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Norman Middle Cobden Last Brown				4. DATE OF DEATH Month January Day 5 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11 July 1939	
9. AGE (In years lost birthday) 17 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Kansas	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Joseph Brown				14. MOTHER'S MAIDEN NAME Marcella Cobden			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT The Medical Record, Clinical Center National Institutes of Health, Bethesda 14, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) gastro-intestinal hemorrhage 204.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) acute lymphatic leukemia DUE TO (c) Unknown cause INTERVAL BETWEEN ONSET AND DEATH 1 d 8 mos ?							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) acute congestion of lungs							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. 1 p. m. Month, Day, Year 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from 27 October , 19 56 , to 5 January , 19 57 , that I last saw the deceased alive on 5 January , 19 57 , and that death occurred at 2:04 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Emery C. Herman, Jr. M.D.				ADDRESS (Street, city or town, state) Clinical Center National Institutes of Health Bethesda 14, Md.			
DATE SIGNED 1/5/57							
PHYSICIAN'S NAME (Type) EMERY C. HERMAN, JR., M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 6/57		22c. NAME OF CEMETERY OR CREMATORY Mt. Lebanon		22d. LOCATION (City, town, or county) (State) Hyattsville Md.	
23. FUNERAL DIRECTOR'S SIGNATURE B. Dargansky & Sons				ADDRESS 3501-14th Wash, D.C.		24a. REC'D BY REGISTRAR DATE 1-8-57	
24b. REGISTRAR'S SIGNATURE Beauregard Thompson							

BUREAU A. 5.

JAN 10 1957

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 223

765

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park				c. LENGTH OF STAY IN 1b 2 days			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington San. and Hosp.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Stephen Middle Lee Last Carter				4. DATE OF DEATH Month Jan. Day 15, Year 1957			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/2/52	9. AGE (In years last birthday) 4 yrs.	IF UNDER 1 YEAR Months 4 Days 4 Hours 4 Min.	IF UNDER 24 HRS. Hours 4 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Myron Miran L. Carter				14. MOTHER'S MAIDEN NAME Ruth Shenk			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no		17. INFORMANT Hosp. Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 936.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Decompressed skull fracture (left) DUE TO (c) 2 days							INTERVAL BETWEEN ONSET AND DEATH 2 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell or pushed from B & O RR bridge					
20c. TIME OF INJURY Month, Day, Year 1/13/57 Hour a. m. 5:15 P M		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Burlington Ave.		20f. (City or town) (County) (State) Silver Spring Montg. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input checked="" type="checkbox"/> .							
ACTUAL SIGNATURE Frank J. Broschart M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Frank J. Broschart				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Jan. 15, 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1/17/57		22c. NAME OF CEMETERY OR CREMATORY CARVER MEMORIAL CEMETERY		22d. LOCATION (City, town, or county) (State) BELTSVILLE, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey				ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR 1/18/57	
				24b. REGISTRAR'S SIGNATURE Wilson Dadd			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
JAN 21 1957
BUREAU V. 3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00775

807

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 55 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Maryland		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Joseph Middle Alfred Last CAREY		4. DATE OF DEATH Month January Day 31 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-24-1882
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lawyer		10b. KIND OF BUSINESS OR INDUSTRY Commercial	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Daniel F. Carey		14. MOTHER'S MAIDEN NAME Sarah Mc Cormick	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. Sp. Am. & WW-I	
17. INFORMANT (Daughter) Mrs. Louise C. Bastion (Same As #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction, old & recent 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) due to Atherosclerotic Heart Disease DUE TO (c) Indef. INTERVAL BETWEEN ONSET AND DEATH 36 hrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Renal Disease, Cerebral Thrombosis			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7 Dec. , 19 56 , to 31 Jan. , 19 57 , that I last saw the deceased alive on 31 Jan. , 19 57 , and that death occurred at 5:55 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 2-1-57			
ACTUAL SIGNATURE R. J. Mc Carthy		M.D. U.S. Naval Hospital, Bethesda, Md.	
PHYSICIAN'S NAME (Type) R. J. Mc Carthy, CDR, MC, USN		U.S. Naval Hospital, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-5-57	
22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE S. H. Hines		ADDRESS 2901 14th St., N.W., Washington, D.C.	
24a. REC'D BY REGISTRAR DATE 2-1-57		24b. REGISTRAR'S SIGNATURE May E. Parrelly	

[illegible]

RECEIVED

FEB 4 1957

BUREAU

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00776

808

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 10 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery Co. General Hospital, Inc.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Rt. 1, Germantown	
3. NAME OF DECEASED (Type or print) First Hobart Middle McKinley Last Case		4. DATE OF DEATH Month January Day 22 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/8/98
9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sheet metal worker		10b. KIND OF BUSINESS OR INDUSTRY North Carolina	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jack Case		14. MOTHER'S MAIDEN NAME Nancy Hyler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 237-26-6087	
17. INFORMANT Hospital Record		Address _____	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malignant Hypertension 445x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 9 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from Jan. 6 , 19 56 , to Jan. 22 , 19 57 , that I last saw the deceased alive on Jan. 22 , 19 57 , and that death occurred at 10:10 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Jack Schumacher M.D.		ADDRESS (Street, city or town, state) Gaithersburg, Md.	
DATE SIGNED _____		DATE SIGNED _____	
PHYSICIAN'S NAME (Type) J. Schumacher			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 25, 1957	
22c. NAME OF CEMETERY OR CREMATORY Salem Methodist		22d. LOCATION (City, town, or county) (State) Cedar Grove, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Edm L. Mottisworth		24a. REC'D BY REGISTRAR DATE 1-24-57	
ADDRESS Damascus, Md.		24b. REGISTRAR'S SIGNATURE Erubide B Lawler	

RECEIVED

FEB 1 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00777

Reg. Dist. No. 216

809ms 1.9 FilmG210 2-1-57 et

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
c. LENGTH OF STAY IN 1b <u>1 1/2</u> years		d. STREET ADDRESS <u>1712 M Street N.E.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital Bethesda 14, Md.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Pricilla</u> Middle <u>Casey</u> Last <u>Casey</u>		4. DATE OF DEATH Month <u>January</u> Day <u>23</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>September 1909</u>
9. AGE (In years last birthday) <u>48</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>4</u> Days <u>17</u> Hours <u>47</u> Min.	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>	11. BIRTHPLACE (State or foreign country) <u>Columbia, South Carolina</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
---	---	---	---

13. FATHER'S NAME <u>Robert Days</u>	14. MOTHER'S MAIDEN NAME <u>Eliza Johnson</u>
--------------------------------------	---

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	16. SOCIAL SECURITY NO. <u>(If yes, give war or dates of service)</u>	17. INFORMANT <u>sister</u> <u>526 4th Street N.E.</u> <u>Washington, D. C.</u>
--	---	---

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>45 minutes</u> <u>5 years</u>
---	--	---

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
---	--	--

20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Walking up flight of stairs and fainted</u>		
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>12:30</u> p. m. <u>1</u> 23 19 57	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>home</u>	20f. (City or town) <u>Chevy Chase</u> (County) <u>Montgomery</u> (State) <u>Maryland</u>

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.	CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED <u>2-23-57</u>
EXAMINER'S NAME (Type) <u>Frank J. Broschart, M. D.</u>	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
	DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1/27/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Columbia, South Carolina</u>	22d. LOCATION (City, town, or county) (State)
---	----------------------------------	--	---

23. FUNERAL DIRECTOR'S SIGNATURE <u>James J. Howard</u> ADDRESS <u>30 H Street, N.E.</u>	24a. REC'D BY REGISTRAR <u>Beaver Thompson</u>	24b. REGISTRAR'S SIGNATURE <u>Beaver Thompson</u>
--	--	---

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be for the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for the files.

MISSISSIPPI STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 3

JAN 28 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

810

CERTIFICATE OF DEATH

00778

Reg. Dist. No.

218

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Fairfax</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg R.F.D.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Herndon</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Nicholson Rest Home</u>		d. STREET ADDRESS <u>83X-3</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Charlotte</u> Middle <u>-</u> Last <u>Chamblin</u>		4. DATE OF DEATH Month <u>1</u> Day <u>19</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 19, 1875</u>
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>Loudoun Co. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Chamblin</u>		14. MOTHER'S MAIDEN NAME <u>Mollie Burson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>-</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Mason Chamblin</u>		Address <u>10000 Denier St Arlington Va.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Stroke - Cranial Hemorrhage</u> DUE TO <u>Generalized Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>Months</u> <u>Years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u> </u> p. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Apr. 16, 1957</u> to <u>Jan. 19, 1956</u> , that I last saw the deceased alive on <u>Jan. 16, 1957</u> , and that death occurred at <u>10:00</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Jack Schumacher</u>		DATE SIGNED <u>Jan. 19, 57</u>	
PHYSICIAN'S NAME (Type) <u>Jack Schumacher M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1-22-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Chestnut Grove Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Herndon, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>G. Berkley Green</u>		ADDRESS <u>Herndon, Va.</u>	
24a. REC'D BY REGISTRAR <u>Jan 19-57</u>		24b. REGISTRAR'S SIGNATURE <u>Charles H. Cook</u>	

Page 10

... ..

Victor H. Best, Home

Chapman - Chaffin

2/5/77

18 24 31, 71, 54

104 502 1043 + 104

Chas. J. ...

1951.10.11

1880

BUREAU V. S.

JAN 24 1957

RECEIVED

811

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY 22	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 37 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Maryland		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
4. DATE OF DEATH Month January Day 17 Year 1957		5. STREET ADDRESS Forrest Hills Drive	
3. NAME OF DECEASED (Type or print) First Joe Middle Arthur Last CHANCE, Sr.		6. DATE OF BIRTH 18 Jan. 1892	
7. SEX Male	8. COLOR OR RACE White	9. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	10. AGE (In years last birthday) 64 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pipefitter		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Lee Andrew Chance		14. MOTHER'S MAIDEN NAME Mary Etta Yates	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 413 07 5349	
17. INFORMANT (Son) Joe Arthur Chance, Jr. (Same As #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 163X DUE TO (b) over Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Carcinoma of Lung, Widely Metastatic PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 6 mos.		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 o. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11 December, 1956 , to 17 January, 1957 , that I last saw the deceased alive on 17 January, 1957 , and that death occurred at 1:05 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE T.S. Dunn, Jr.		ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Maryland	
PHYSICIAN'S NAME (Type) T.S. Dunn, Jr., LT, MC, USN		DATE SIGNED U.S. Naval Hospital, Bethesda, Md. 1-17-57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-21-57	
22c. NAME OF CEMETERY OR CREMATORY Olive Hill Cemetery		22d. LOCATION (City, town, or county) (State) Savannah, Tennessee	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey		24a. REC'D BY REGISTRAR 1-17-57	
ADDRESS 557 Wisconsin Ave., Bethesda, Md		24b. REGISTRAR'S SIGNATURE Wm. E. Passell	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 6 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

U.S. DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

NAME (Last, first, middle)		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES EARL RAY		MALE		35		APR 14 1928		MOBILE		ALABAMA		U.S.A.		U.S.A.	
RACE		COLOR		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		MILITARY SERVICE		REMARKS	
WHITE		WHITE		METHODIST		MARRIED		HIGH SCHOOL		CLOCK REPAIRER		U.S. ARMY		KILLED IN ACTION	
DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY		CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE NO.	
APR 4 1968		MEMPHIS		TENNESSEE		U.S.A.		U.S.A.		SHOOTING		MURDER		100-457611	
SIGNATURE OF REGISTRAR		SIGNATURE OF PHYSICIAN		SIGNATURE OF CLERK		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. 3

JAN 21 1967

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00780

786

CERTIFICATE OF DEATH

Reg. Dist. No.

213

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>DOVER ROAD</u>				d. STREET ADDRESS <u>1 DOVER Rd.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>MARTHA</u> First <u>P.</u> Middle <u>CHASE</u> Last				4. DATE OF DEATH <u>JAN.</u> Month <u>18</u> Day <u>1957</u> Year			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>NEGRO</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-16-1884</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>DOUGLAS Poynter</u>				14. MOTHER'S MAIDEN NAME <u>MILLIE (UNKNOWN)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Insurance Form</u> Address <u>DOVER RD</u>		18. BIRTHPLACE (State or foreign country) <u>Rockville</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL THROMBOSIS</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIOSCLEROSIS</u> DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>Oct.</u> , 19 <u>56</u> to <u>DEATH</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>DEC. 23</u> , 19 <u>56</u> , and that death occurred at <u>10:00</u> P.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Clive E. Jackson</u> , M.D.				ADDRESS (Street, city or town, state) <u>RD 1, Gaithersburg, Md.</u> DATE SIGNED <u>1-19-57</u>			
PHYSICIAN'S NAME (Type) <u>Clive E. Jackson</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1/22/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Park</u>		22d. LOCATION (City, town, or county) <u>Rockville, Md.</u> (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert E. Snowden - Rockville, Md.</u> ADDRESS _____				24a. REC'D BY REGISTRAR <u>DATE 28 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Lawrence H. Hargrove</u>	

00

1

0

0

BP

1

BUREAU V. S.

JAN 28 1957

RECEIVED

812

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>4 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>MARJORIE Louise</u> First Middle Last				4. DATE OF DEATH <u>CHRISTIE</u> Month Day Year <u>1 - 30 1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>11-13-24</u>	
9. AGE (In years last birthday) <u>32</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Physicist</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Government</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>	
13. FATHER'S NAME <u>BURTON P. Williams</u>				14. MOTHER'S MAIDEN NAME <u>MARIAN CARSON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT Address <u>35, md. Rachel CARSON (aunt) 204 Williamsburg Drive</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Right Lower Lobe Pneumonia</u> DUE TO <u>with abscess formation</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>490x</u> (b) <u>260x</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus; Heart block undet. cause</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>52</u> , to <u>Jan 30</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Jan 29</u> , 19 <u>57</u> , and that death occurred at <u>8:10 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Michel M. Healy</u>				ADDRESS (Street, city or town, state) <u>Washington, D.C.</u>			
PHYSICIAN'S NAME (Type) <u>Michel M. Healy</u>				DATE SIGNED <u>1/30/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 1, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Montgomery County, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner C. Pumphrey</u>				ADDRESS <u>Silver Spring, Md.</u>		24a. REC'D BY REGISTRAR <u>2-1-57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Bennie M. Thompson</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4.

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, age, sex, race, cause of death, and place of death. The form is filled out with handwritten text.

DECEASED
Name: *James M. [illegible]*
Age: *45*
Sex: *M*
Race: *W*
Cause of Death: *Heart Disease*
Place of Death: *Home*

BUREAU V. 3

FEB 4 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

813

CERTIFICATE OF DEATH

Reg. Dist. No.

00782

212

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Barnesville				c. LENGTH OF STAY IN 1b 84 yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Clara Virginia Claggett				4. DATE OF DEATH Month Day Year January 6 1957			
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 1st. 1872		9. AGE (In years last birthday) 84 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Lawson Butler				14. MOTHER'S MAIDEN NAME Nancy Welch			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address George Claggett, Barnesville, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident, left hemiplegia 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive c. Arteriosclerotic Vascular Disease DUE TO (c) 14 years							INTERVAL BETWEEN ONSET AND DEATH 5 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from May 22, 1952 , to 6 January 1957 , that I last saw the deceased alive on 5 January, 1957 , and that death occurred at 11:00 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Gordon M. Smith				ADDRESS (Street, city or town, state) Barnesville, Md.			
PHYSICIAN'S NAME (Type) Gordon M. Smith				DATE SIGNED 7 Jan 57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/8/57		22c. NAME OF CEMETERY OR CREMATORY Friendship		22d. LOCATION (City, town, or county) (State) Damascus Md.	
23. FUNERAL DIRECTOR'S SIGNATURE William B. Hatten				ADDRESS Barnesville, Md.		24a. REC'D BY REGISTRAR DATE 1/8/57	
				24b. REGISTRAR'S SIGNATURE Charles W. Edgin		per per 086	

—continued

5780292

of five articles

1997

of 1999.

140-12

2000

2000-01-01

Sample name:

[illegible]

Jenny Wilson

Lawson, William

George C. [unclear]

500

GK

BUREAU V.

10 1957

RECEIVED

vide infra.

73181

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

814

CERTIFICATE OF DEATH

00783

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON				c. LENGTH OF STAY IN 1b X 2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION KENSINGTON GARDENS SANITARIUM				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) NELLIE First WALKER Middle CLEPHANE Last				4. DATE OF DEATH Month 1 Day 7 Year 1957			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 4, 1868	9. AGE (In years last birthday) 89 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Walker				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address Kensington, Md John W. Clephane, 3403 Oberon St.,			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchio pneumonia 904.7 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fractured left hip (head of femur) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 3 days 34 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell in bathroom, fracturing lt. femur.			
20c. TIME OF INJURY Hour a. 4 p. m. Month 12 Day 4 Year 1956				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input checked="" type="checkbox"/> at work <input type="checkbox"/> Not at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Manning Camp, Kensington-Montgomery, Md.	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Dec 4, 1956 to Jan 7, 1957 , that I last saw the deceased alive on Jan 7, 1957 , and that death occurred at 8:40 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Alaysia J. Leamy, M.D.				ADDRESS (Street, city or town, state) 1635 Irving St. N.W.			
DATE SIGNED							
PHYSICIAN'S NAME (Type) ALAYSIA J. CONNOLLY, M.D.				ADDRESS Washington 10, D.C.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/11/57		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Lawler Sons				ADDRESS 1756 Pennsylvania Ave NW, Washington, DC		24a. REC'D BY REGISTRAR DATE 10-57	
				24b. REGISTRAR'S SIGNATURE Bennie M. Thompson			

Coroner notified & Will
Approve Jan 7th 1957

JAN 14 1957

BUREAU V. S.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 FilmG209 1-15-57 et

815

CERTIFICATE OF DEATH

Reg. Dist. No.

00784
214

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Norbeck				c. LENGTH OF STAY IN 1b 13 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 16x02	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Bradford Rest Home				d. STREET ADDRESS Rt. 1 Silver Spring,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Collins Last Collins				4. DATE OF DEATH Month January Day 6 Year 1957			
5. SEX male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/7/80	
9. AGE (In years from birthday) 77 1/2 yrs.		IF UNDER 1 YEAR Months 11 Days 16 Hours 0 Min. 0		IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Saundersville, Ga.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John Collins				14. MOTHER'S MAIDEN NAME Brown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give or unknown) No (If yes, give year or dates of service) No				16. SOCIAL SECURITY NO. 240 09 6394		17. INFORMANT Bradford Rest Home Silver Spring	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema Cardiorenal Decomp. 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiorenal Hypertension with Edema DUE TO (c) lyr.				INTERVAL BETWEEN ONSET AND DEATH 3 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Suprapubic prostatectomy with indwelling catheter				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) none				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Dec. , 19 55 to Jan. 6 , 19 57 , that I last saw the deceased alive on Jan. 5 , 19 57 , and that death occurred at 6:40 M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Norbeck Rt. 1 Silv. Sp. DATE SIGNED 1-6-57							
ACTUAL SIGNATURE Webster Sewell M.D.				PHYSICIAN'S NAME (Type) Webster Sewell, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-10-57		22c. NAME OF CEMETERY OR CREMATORY Lincoln --Frederick		22d. LOCATION (City, town, or county) (State) Sentinel Rd Md	
23. FUNERAL DIRECTOR'S SIGNATURE Henry S. Washington				ADDRESS 467 N st. N.W.		24a. REC'D BY REGISTRAR DATE 10 1957	
24b. REGISTRAR'S SIGNATURE Frances Patter							

CERTIFICATE OF DEATH

878

NAME OF DECEASED JAMES EARL RAY		SEX Male		AGE 35	
DATE OF DEATH April 4, 1968		PLACE OF DEATH St. Louis, Missouri		CITY St. Louis	
CAUSE OF DEATH Suicide by gunshot		MANNER OF DEATH Homicide		DISEASE OR INJURY Suicide	
DATE OF BIRTH March 21, 1933		PLACE OF BIRTH St. Louis, Missouri		CITY St. Louis	
FATHER'S NAME JAMES EARL RAY		MOTHER'S NAME JANET BEATRICE RAY		DATE OF MARRIAGE June 12, 1955	
EDUCATION High School Graduate		OCCUPATION Attorney		RELIGION Methodist	
MARITAL STATUS Married		SPOUSE'S NAME JANET BEATRICE RAY		DATE OF MARRIAGE June 12, 1955	
PREVIOUS MARRIAGES None		SPOUSE'S OCCUPATION Homemaker		SPOUSE'S RELIGION Methodist	
DATE OF DEATH April 4, 1968		PLACE OF DEATH St. Louis, Missouri		CITY St. Louis	
CAUSE OF DEATH Suicide by gunshot		MANNER OF DEATH Homicide		DISEASE OR INJURY Suicide	
DATE OF BIRTH March 21, 1933		PLACE OF BIRTH St. Louis, Missouri		CITY St. Louis	
FATHER'S NAME JAMES EARL RAY		MOTHER'S NAME JANET BEATRICE RAY		DATE OF MARRIAGE June 12, 1955	
EDUCATION High School Graduate		OCCUPATION Attorney		RELIGION Methodist	
MARITAL STATUS Married		SPOUSE'S NAME JANET BEATRICE RAY		DATE OF MARRIAGE June 12, 1955	
PREVIOUS MARRIAGES None		SPOUSE'S OCCUPATION Homemaker		SPOUSE'S RELIGION Methodist	

BUREAU V. 8

JAN 10 1967

RECEIVED

816

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Mont</u> <u>214</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Garden Sanitarium</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>John W Colton</u>				4. DATE OF DEATH Month <u>1</u> - Day <u>7</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-19-76</u>		9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Insurance</u>		11. BIRTHPLACE (State or foreign country) <u>Milwaukee Wis</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>I</u>		16. SOCIAL SECURITY NO. <u>349-0378</u>		17. INFORMANT <u>Col. George S. Lavenson</u>		Address <u>349-0378</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Embolage</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>A.S.C.V.D.</u> DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u> <u>years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>12/8</u> , 19 <u>56</u> , to <u>1/7</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1/6/57</u> , 19 <u>57</u> , and that death occurred at <u>2:00</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Charles M. Weber</u>				ADDRESS (Street, city or town, state) <u>12600 PARKLAND Dr., Rockville Md</u>			
PHYSICIAN'S NAME (Type) <u>Charles M. Weber</u>				DATE SIGNED <u>1/7/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>1-9-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Swirland Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Real Funeral Home</u>				ADDRESS <u>4812 S. Ave 2nd</u>		24a. REC'D BY REGISTRAR DATE <u>1-12-57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Frances Potter</u>			

CERTIFICATE OF DEATH

Name of Deceased <i>John V. [illegible]</i>		Sex <i>Male</i>		Age <i>38</i>	
Date of Death <i>Jan 16 1957</i>		Place of Death <i>Home</i>		Cause of Death <i>[illegible]</i>	
Occupation <i>[illegible]</i>		Usual Residence <i>[illegible]</i>		Manner of Death <i>[illegible]</i>	
Signature of Physician <i>[illegible]</i>		Signature of Registrar <i>[illegible]</i>		Signature of Coroner <i>[illegible]</i>	
City <i>[illegible]</i>		County <i>[illegible]</i>		State <i>[illegible]</i>	

BUREAU V. S.

JAN 16 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

00786
214

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u> c. LENGTH OF STAY IN 1b <u>life</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4000 Lawrence Ave.</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u> d. STREET ADDRESS <u>4000 Lawrence Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) First <u>Francis</u> Middle <u>Gregory</u> Last <u>Conley</u>				4. DATE OF DEATH Month <u>Jan</u> Day <u>30</u> Year <u>1957</u>													
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 21 1956</u>		9. AGE (In years last birthday) yrs. <u>3</u> Months <u>9</u> Days <u>9</u> Hours <u>Min.</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) _____		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Edward S. Conley</u>						14. MOTHER'S MAIDEN NAME <u>Amelia Spitzer Conley</u>											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.				17. INFORMANT <u>Edward Conley - (father)</u>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>501x Fulminant Strychnine-poisoning -</u> DUE TO (b) <u>bronchitis</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (c) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Constipation, Enlarged Thyroid</u>												INTERVAL BETWEEN ONSET AND DEATH <u>Two hrs?</u>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>																	
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>												DATE SIGNED <u>1-30-57</u>					
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>												DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				22b. DATE THEREOF <u>2/2/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVET CEMETERY</u>				22d. LOCATION (City, town, or county) <u>WASHINGTON, D.C.</u>				(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter E. Humphrey</u>						ADDRESS <u>SILVER SPRING, MD.</u>				24a. REC'D BY REGISTRAR <u>1/31/57</u>		24b. REGISTRAR'S SIGNATURE <u>Francis C. Otter</u>					

9VVVVVVVVVV

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be for the records of the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination and death certification, including fields for name, date, time, place, and cause of death. The form is mostly blank with some faint markings.

BUREAU V. 3.

FEB 5 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 2 and 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

818

CERTIFICATE OF DEATH

Reg. Dist. No. 218

00787

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Gaithersburg</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Gaithersburg</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Rural</i>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Mary Virginia Connors</i>		4. DATE OF DEATH <i>January-24-1957</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct-12-1896</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>house-keeping</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>at home</i>	
11. BIRTHPLACE (State or foreign country) <i>Rockville Md-Route 1</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
13. FATHER'S NAME <i>Erasmus Kest</i>		14. MOTHER'S MAIDEN NAME <i>Betty Cross</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>none</i>	
17. INFORMANT <i>Martha E. Cochran, Gaithersburg Md. R-3</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Viral infection</i> <i>096.9</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <i>8 days</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Senility</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Jan-17-1957</i> to <i>Jan-24-1957</i> , that I last saw the deceased alive on <i>Jan-23-1957</i> , and that death occurred at <i>3:30 A.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>William C. Miller</i> M.D.		ADDRESS (Street, city or town, state) <i>7-Brookview, Gaithersburg, Md.</i>	
PHYSICIAN'S NAME (Type) <i>W. C. MILLER, M.D.</i>		DATE SIGNED <i>GAITHERSBURG, MD.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>1/26/57</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Forest Oak</i>		22d. LOCATION (City, town, or county) (State) <i>Gaithersburg, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey-Bethesda, Md.</i>		ADDRESS	
24a. REC'D BY REGISTRAR <i>1-25-57</i>		24b. REGISTRAR'S SIGNATURE <i>Charles G. Cooke</i>	

BUREAU V. S.

JAN 29 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **40788**

819

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			
c. LENGTH OF STAY IN 1b 7 months				d. STREET ADDRESS 4527 Rosedale Avenue			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) driveway-4527 Rosedale Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Thomas Middle A. Last COVER				4. DATE OF DEATH Month January Day 9 Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 27, 1904	
9. AGE (In years last birthday) 52 yrs.		IF UNDER 1 YEAR Months 6 Days 12		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Employee				10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy-Civilian		11. BIRTHPLACE (State or foreign country) Washington, D. C.	
				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Charles B. Cover				14. MOTHER'S MAIDEN NAME Anne Baublitz			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Harriet Cover- Same Item #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) 				INTERVAL BETWEEN ONSET AND DEATH sudden			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Frank J. Broschart				DATE SIGNED January 9m 1957			
EXAMINER'S NAME (Type) Frank J. Broschart, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/12/1957		22c. NAME OF CEMETERY OR CREMATORY Prospect Hill		22d. LOCATION (City, town, or county) (State) Washington D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-7557 Wis. Ave. Beth. Md.				24a. REC'D BY REGISTRAR DATE-10-57		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Death	
John Doe		Male		45		1957-01-15	
Place of Birth		Usual Residence		Cause of Death		Manner of Death	
Baltimore, Md.		Baltimore, Md.		Heart Disease		Natural	
Occupation		Education		Signature of Examiner		Signature of Coroner	
Teacher		High School		[Signature]		[Signature]	
Social Security No.		Marital Status		Date of Burial		Place of Burial	
123-456789		Married		1957-01-20		Catholic Cemetery	

BUREAU V. 81

JAN 15 1957

RECEIVED

County of Baltimore, Md.
I, [Signature], Coroner of the County of Baltimore, do hereby certify that the above is a true and correct copy of the Medical Examiner's Certificate of Death for the body of John Doe, deceased, on January 15, 1957.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G210 2-13-57 et

CERTIFICATE OF DEATH

Reg. Dist. No.

00789

820

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>				c. LENGTH OF STAY IN 1b <u>2 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X 2 Rt. #1 Rockville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery County General Hospital</u>				d. STREET ADDRESS <u>None</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>Montgomery</u> Last <u>Crown</u>				4. DATE OF DEATH Month <u>January</u> Day <u>27</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 3, 1877</u>		9. AGE (In years lost birthday) <u>79</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter; Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Crown</u>				14. MOTHER'S MAIDEN NAME <u>Virginia Ricketts</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>578-05-5822</u>		17. INFORMANT <u>George W. Crown</u> Address <u>410 Reading Ave. Rockville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> <u>443x</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <u>HYPERTENSION</u> DUE TO (c) <u>ARTERIO SCLEROSIS</u> INTERVAL BETWEEN ONSET AND DEATH <u>5 YEARS</u> <u>15 YEARS</u> <u>15 YEARS</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>January 24, 1957</u> , to <u>January 27, 1957</u> , that I last saw the deceased alive on <u>January 27, 1957</u> , and that death occurred at <u>8:18 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>26 N Sumner St. Gaithersburg, Md.</u> Jan. 27, 1957 ACTUAL SIGNATURE <u>Gordon S. Rosenberger</u> M.D. DATE SIGNED PHYSICIAN'S NAME (Type) <u>Dr. G.S. Rosenberger</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/30-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Forest Oak</u>		22d. LOCATION (City, town, or county) (State) <u>Gaithersburg, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Sumphrey</u> ADDRESS <u>Bethesda, Md.</u>				24a. REC'D BY REGISTRAR <u>DATE 1-29-57</u>		24b. REGISTRAR'S SIGNATURE <u>Gertrude B. Sawyer</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. DATE OF BIRTH May 19, 1922		5. PLACE OF BIRTH Jackson, Mississippi	
6. OCCUPATION Attorney		7. MARITAL STATUS Single		8. COLOR White		9. HEIGHT 5' 10"		10. WEIGHT 170	
11. CAUSE OF DEATH Suicide		12. MANNER OF DEATH Homicide		13. PLACE OF DEATH Baltimore, Maryland		14. DATE OF DEATH June 4, 1968		15. TIME OF DEATH 10:10 AM	
16. SIGNATURE OF DECEASED James Earl Ray		17. SIGNATURE OF WITNESS John Edgar Hoover		18. SIGNATURE OF PHYSICIAN John Edgar Hoover		19. SIGNATURE OF CORONER John Edgar Hoover		20. SIGNATURE OF JURY John Edgar Hoover	
21. SIGNATURE OF DECEASED James Earl Ray		22. SIGNATURE OF WITNESS John Edgar Hoover		23. SIGNATURE OF PHYSICIAN John Edgar Hoover		24. SIGNATURE OF CORONER John Edgar Hoover		25. SIGNATURE OF JURY John Edgar Hoover	
26. SIGNATURE OF DECEASED James Earl Ray		27. SIGNATURE OF WITNESS John Edgar Hoover		28. SIGNATURE OF PHYSICIAN John Edgar Hoover		29. SIGNATURE OF CORONER John Edgar Hoover		30. SIGNATURE OF JURY John Edgar Hoover	
31. SIGNATURE OF DECEASED James Earl Ray		32. SIGNATURE OF WITNESS John Edgar Hoover		33. SIGNATURE OF PHYSICIAN John Edgar Hoover		34. SIGNATURE OF CORONER John Edgar Hoover		35. SIGNATURE OF JURY John Edgar Hoover	
36. SIGNATURE OF DECEASED James Earl Ray		37. SIGNATURE OF WITNESS John Edgar Hoover		38. SIGNATURE OF PHYSICIAN John Edgar Hoover		39. SIGNATURE OF CORONER John Edgar Hoover		40. SIGNATURE OF JURY John Edgar Hoover	
41. SIGNATURE OF DECEASED James Earl Ray		42. SIGNATURE OF WITNESS John Edgar Hoover		43. SIGNATURE OF PHYSICIAN John Edgar Hoover		44. SIGNATURE OF CORONER John Edgar Hoover		45. SIGNATURE OF JURY John Edgar Hoover	
46. SIGNATURE OF DECEASED James Earl Ray		47. SIGNATURE OF WITNESS John Edgar Hoover		48. SIGNATURE OF PHYSICIAN John Edgar Hoover		49. SIGNATURE OF CORONER John Edgar Hoover		50. SIGNATURE OF JURY John Edgar Hoover	
51. SIGNATURE OF DECEASED James Earl Ray		52. SIGNATURE OF WITNESS John Edgar Hoover		53. SIGNATURE OF PHYSICIAN John Edgar Hoover		54. SIGNATURE OF CORONER John Edgar Hoover		55. SIGNATURE OF JURY John Edgar Hoover	
56. SIGNATURE OF DECEASED James Earl Ray		57. SIGNATURE OF WITNESS John Edgar Hoover		58. SIGNATURE OF PHYSICIAN John Edgar Hoover		59. SIGNATURE OF CORONER John Edgar Hoover		60. SIGNATURE OF JURY John Edgar Hoover	
61. SIGNATURE OF DECEASED James Earl Ray		62. SIGNATURE OF WITNESS John Edgar Hoover		63. SIGNATURE OF PHYSICIAN John Edgar Hoover		64. SIGNATURE OF CORONER John Edgar Hoover		65. SIGNATURE OF JURY John Edgar Hoover	
66. SIGNATURE OF DECEASED James Earl Ray		67. SIGNATURE OF WITNESS John Edgar Hoover		68. SIGNATURE OF PHYSICIAN John Edgar Hoover		69. SIGNATURE OF CORONER John Edgar Hoover		70. SIGNATURE OF JURY John Edgar Hoover	
71. SIGNATURE OF DECEASED James Earl Ray		72. SIGNATURE OF WITNESS John Edgar Hoover		73. SIGNATURE OF PHYSICIAN John Edgar Hoover		74. SIGNATURE OF CORONER John Edgar Hoover		75. SIGNATURE OF JURY John Edgar Hoover	
76. SIGNATURE OF DECEASED James Earl Ray		77. SIGNATURE OF WITNESS John Edgar Hoover		78. SIGNATURE OF PHYSICIAN John Edgar Hoover		79. SIGNATURE OF CORONER John Edgar Hoover		80. SIGNATURE OF JURY John Edgar Hoover	
81. SIGNATURE OF DECEASED James Earl Ray		82. SIGNATURE OF WITNESS John Edgar Hoover		83. SIGNATURE OF PHYSICIAN John Edgar Hoover		84. SIGNATURE OF CORONER John Edgar Hoover		85. SIGNATURE OF JURY John Edgar Hoover	
86. SIGNATURE OF DECEASED James Earl Ray		87. SIGNATURE OF WITNESS John Edgar Hoover		88. SIGNATURE OF PHYSICIAN John Edgar Hoover		89. SIGNATURE OF CORONER John Edgar Hoover		90. SIGNATURE OF JURY John Edgar Hoover	
91. SIGNATURE OF DECEASED James Earl Ray		92. SIGNATURE OF WITNESS John Edgar Hoover		93. SIGNATURE OF PHYSICIAN John Edgar Hoover		94. SIGNATURE OF CORONER John Edgar Hoover		95. SIGNATURE OF JURY John Edgar Hoover	
96. SIGNATURE OF DECEASED James Earl Ray		97. SIGNATURE OF WITNESS John Edgar Hoover		98. SIGNATURE OF PHYSICIAN John Edgar Hoover		99. SIGNATURE OF CORONER John Edgar Hoover		100. SIGNATURE OF JURY John Edgar Hoover	

BUREAU V. E.

FEB 6 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

821

CERTIFICATE OF DEATH

Reg. Dist. No. 101780

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>45 minutes</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>26 Chevy Chase</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Suburban Hospital</u>				d. STREET ADDRESS <u>14601-Willard Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Idamora J. Darlington</u>				4. DATE OF DEATH Month Day Year <u>Jan. 4 1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH <u>July 11, 1885</u>		9. AGE (In years last birthday) yrs. Months Days Hours Min. <u>71</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Whitcomb's (retired)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Gov't</u>		11. BIRTHPLACE (State or foreign country) <u>Alabama</u>	
13. FATHER'S NAME <u>George Johnston</u>				14. MOTHER'S MAIDEN NAME <u>Martha Darlington</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Eleanor A. Darlington</u>		Address <u>14601-Willard Ave. Chevy Chase, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion, recurrent</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) <u>2 1/2</u> INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1/5</u> , 19 <u>55</u> , to <u>1/4</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1/4</u> , 19 <u>57</u> , and that death occurred at <u>5:30 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>J. L. Marks</u> M.D. <u>6306 Wisconsin Ave</u> PHYSICIAN'S NAME (Type) <u>Dr. I. L. Marks</u> <u>6306 Wisconsin Ave., Chevy Chase, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 7, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) <u>Allendale, South Carolina.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Chevy Chase Funeral Home</u>				ADDRESS <u>5103 Wisconsin Ave.</u>		24a. REC'D BY REGISTRAR DATE <u>1-7-57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>			

STATE DEPARTMENT OF HEALTH—BALTIMORE 18

uncontrollable and persistent
and persistent
and health F-1054

12 11 prof. naturalists

St. Louis, Mo. 1892

notary of public

not published at 10 PM

BUREAU V.

JAN 10 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

00791

216

822

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>WASH.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>20 hours</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington 478-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				d. STREET ADDRESS <u>1422-Rhode Is Ave NW</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>HELEN</u> Middle <u>Miles</u> Last <u>Davis</u>				4. DATE OF DEATH <u>6:35 PM</u> JAN - 25 19 57			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 15 - 1895</u>	
9. AGE (In years last birthday) <u>61</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Editor, Chemist</u>		11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Miles, Henry R.</u>				14. MOTHER'S MAIDEN NAME <u>Ketcham, Charlotte</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>579-48-9153</u>		17. INFORMANT <u>Watson Davis - (Above) - Husband</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma (to lungs)</u> DUE TO <u>Schirrhous grade of Breast Carcinoma (the primary)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>17</u> DUE TO (c) <u>11 months</u>				INTERVAL BETWEEN ONSET AND DEATH <u>11 months</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>March, 1956</u> , to <u>Jan 25, 1957</u> , that I last saw the deceased alive on <u>Jan 25, 1957</u> , and that death occurred at <u>6:35 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Michel M. Healy</u>				ADDRESS (Street, city or town, state) <u>Washington D.C.</u> DATE SIGNED <u>1/25/57</u>			
PHYSICIAN'S NAME (Type) <u>Michel M. Healy</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>1/29/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Crematory Prince Georges County, Md.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.</u> ADDRESS <u>2901 14th St., N.W. DC</u>				24. REC'D BY REGISTRAR <u>Jan 28 1957</u> 24b. REGISTRAR'S SIGNATURE <u>Bessie Thompson</u>			

BUREAU V. 3

1957 28 JAN

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 6 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 217

00792

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 4 hours	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montg. Co. Gen. Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Titus Deets Day		4. DATE OF DEATH Month Day Year Jan. 20 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 19, 1898
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Operated a general store		10b. KIND OF BUSINESS OR INDUSTRY Lewisdale, Md.	
13. FATHER'S NAME Titus W. Day		14. MOTHER'S MAIDEN NAME Rosa B. King	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218-32-3461	
17. INFORMANT Mrs Hilda L. Day, Monrovia, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage, large, basal 331x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio-sclerosis, generalized DUE TO (c) Hypertension, marked obesity		INTERVAL BETWEEN ONSET AND DEATH 4 hours ? ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. s. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June , 19 55 , to 1/20/57 , 19 57 , that I last saw the deceased alive on 1/20/57 , 19 57 , and that death occurred at 6:15P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Damascus, Maryland 1/21/57 ACTUAL SIGNATURE G. F. Meadors, M.D. PHYSICIAN'S NAME (Type) G. F. Meadors, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 23, 1957	
22c. NAME OF CEMETERY OR CREMATORY Bethesda		22d. LOCATION (City, town, or county) (State) Browningsville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Chas. I. Moleman		24a. REC'D BY REGISTRAR DATE 1-23-57	
ADDRESS Damascus, Md.		24b. REGISTRAR'S SIGNATURE Leah B. Lawler	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

NAME OF DECEASED		DATE OF BIRTH	
JAMES E. JONES		JAN 15 1925	
MARRIAGE		DATE OF MARRIAGE	
MARRIED		JAN 15 1945	
PLACE OF BIRTH		DATE OF DEATH	
BALTIMORE, MD.		JAN 28 1957	
CAUSE OF DEATH		PLACE OF DEATH	
HEART DISEASE		BALTIMORE, MD.	
MANNER OF DEATH		DATE OF INTERMENT	
NATURAL		JAN 28 1957	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
JAMES E. JONES		JAMES E. JONES	

BUREAU V. 2

JAN 28 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the Registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

824

CERTIFICATE OF DEATH

Reg. Dist. No.

00793
215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 8 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) U.S. Naval Hospital, Bethesda, Md.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				d. STREET ADDRESS 527 Alexander Place			
3. NAME OF DECEASED (Type or print) First SKINNER, Jr. Middle (nmn) Last Donald				4. DATE OF DEATH Month January Day 24 Year 19 57			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-17-57	
9. AGE (In years last birthday) yrs. 7		IF UNDER 1 YEAR Months 9 Days 7 Hours 19 Min. 57		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Donald Skinner			
14. MOTHER'S MAIDEN NAME Joyce L. Brown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None	
17. INFORMANT Father, Donald Skinner (Same as #2)		Address				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Interstitial Pneumonia 763.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Prematurity (c) Prematurity PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 763.5 INTERVAL BETWEEN ONSET AND DEATH 60 hrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. 9 p. m. Month 19 Day 19 Year 19 57		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 17 January, 19 57 , to 24 January, 19 57 , that I last saw the deceased alive on 24 January, 19 57 , and that death occurred at 10:55A , from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 1-25-57 ACTUAL SIGNATURE J.C. Parke Jr. M.D. U.S. Naval Hospital, Bethesda, Md. 1-25-57 PHYSICIAN'S NAME (Type) J.C. PARKE, JR. LT, MC, USN U.S. Naval Hospital, Bethesda, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-30-57		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE W.H. Bacon, 1722 7th St., N.W. Washington, D.C.				24a. REC'D BY REGISTRAR DATE 1-25-57		24b. REGISTRAR'S SIGNATURE Harry E. Russell	

2051214XV3

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the legal facts prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00794

825

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 1 day	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Maryland		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lewis Middle Joseph Last DRAWDY		4. DATE OF DEATH Month January Day 28 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-27-57
9. AGE (In years lost birthday) yrs. 1		10. IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		11b. KIND OF BUSINESS OR INDUSTRY None	
11c. BIRTHPLACE (State or foreign country) Maryland		11d. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Jack William DRAWDY		14. MOTHER'S MAIDEN NAME Viola Lillian Ellis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Father, Jack W. Drawdy (Same As #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Primary Atelectasis 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Prematurity (c) Prematurity		INTERVAL BETWEEN ONSET AND DEATH 32 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. 11. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 27 Jan. , 19 57 , to 28 Jan. , 19 57 , that I last saw the deceased alive on 28 Jan. , 19 57 , and that death occurred at 6:45 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE J.C. Parke		DATE SIGNED U.S. Naval Hospital, Bethesda, Md. 1-29-57	
PHYSICIAN'S NAME (Type) J.C. PARKE, Jr. LT, MC, USN		U.S. Naval Hospital, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-31-57	
22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS R.A. Pumphrey, 7557 Wisconsin Ave., Bethesda, Md.	
24a. REC'D BY REGISTRAR 1-29-57		24b. REGISTRAR'S SIGNATURE Ray E. Parrelly	

JAN

30

1957

BUREAU V. 5

RECEIVED

826
CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7006 Brookville Road				d. STREET ADDRESS 6812 Conn. Ave.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED JAMES First Martin Middle Eiker Last				4. DATE OF DEATH Month January Day 13 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 31, 1881	
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months 7 Days 12		IF UNDER 24 HRS. Hours 12 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. - Artist				10b. KIND OF BUSINESS OR INDUSTRY Self Emp.		11. BIRTHPLACE (State or foreign country) Washington, D.C.	
12. CITIZEN OF WHAT COUNTRY? US							
13. FATHER'S NAME James M. Eiker				14. MOTHER'S MAIDEN NAME Agnes Strobel			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Arthur M. Eiker-Item # 1			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Artery Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Artery Sclerosis DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 7 days years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from January 7, 1957 to January 13, 1957 , that I last saw the deceased alive on January 11, 1957 , and that death occurred at 11:55 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 5516 Neb. Ave. D.C. DATE SIGNED 1-13-57							
ACTUAL SIGNATURE Robert B. Havell				PHYSICIAN'S NAME (Type) Robert B. Havell M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/16/57		22c. NAME OF CEMETERY OR CREMATORY Rock Creek		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumfrey-Bethesda, Md.				24a. REC'D BY REGISTRAR DATE 1-15-57		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DATE OF DEATH		PLACE OF DEATH	
JAN 17 1957		BALTIMORE, MD	
DECEASED'S NAME		SEX	
JAMES H. BROWN		Male	
DATE OF BIRTH		PLACE OF BIRTH	
JAN 17 1900		BALTIMORE, MD	
OCCUPATION		CAUSE OF DEATH	
None		None	
MANNER OF DEATH		SIGNATURE OF PHYSICIAN	
None		[Signature]	
DATE OF INTERMENT		PLACE OF INTERMENT	
JAN 17 1957		BALTIMORE, MD	
NAME OF FUNERAL HOME		NAME OF BURIAL PLACE	
None		None	
NAME OF WITNESSES		NAME OF REGISTRAR	
None		None	

RECEIVED
 JAN 17 1957
 BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00796

827

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Maryland		c. LENGTH OF STAY IN 1b 13 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 3403 Wheeler Road, S. E.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Bertha Middle Aline Last Eldred		4. DATE OF DEATH Month January Day 2 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 4, 1874
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William I. Winne		14. MOTHER'S MAIDEN NAME Jane Godwin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest postoperatively, cause unknown 191X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Squamous Cell Carcinoma of Face and Neck DUE TO (c) Secondary Arteriosclerosis with Interarterial Calcification		INTERVAL BETWEEN ONSET AND DEATH 1 yr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized Arteriosclerosis with Interarterial Calcification		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from December 20, 1956 , to January 2, 1957 , that I last saw the deceased alive on January 2, 1957 , and that death occurred at 4:30 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Robert W. Weiger		M.D. The Clinical Center	
PHYSICIAN'S NAME (Type) Robert W. Weiger, M. D.		National Institutes of Health Bethesda 14, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal Jan. 5, 1957		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Leis Cemetery		22d. LOCATION (City, town, or county) (State) Washington DC	
23. FUNERAL DIRECTOR'S SIGNATURE J. Kullman Leis Son Co 300-4th St NW		24a. REC'D BY REGISTRAR DATE 1-5-57	
24b. REGISTRAR'S SIGNATURE Berrie M. Shorff			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00797

828

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>District of Columbia</u> b. COUNTY <u>Mont.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		d. STREET ADDRESS <u>15425 Conn. Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>Dorothy Ann Emerson</u>		4. DATE OF DEATH <u>1-21-1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-23-10</u>
9. AGE (In years last birthday) <u>46</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>7</u> Days <u>28</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Secretary</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BANKING</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>FRANK B. CROVO, Jr.</u>		14. MOTHER'S MAIDEN NAME <u>Katherine Beckstein</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>577-22-321</u>	
17. INFORMANT <u>Aubrey (brother)</u>		Address <u>Bethesda, Md. 5328 Goldsboro Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Esophageal Varices & Internal Hemorrhage</u> <u>581.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cirrhosis of Liver</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>70 hours</u> <u>Unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. 11. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov</u> , 19 <u>47</u> , to <u>Jan 21</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>January 20</u> , 19 <u>57</u> , and that death occurred at <u>1:20 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>8237 Georgia Ave Silver Spring Md</u> DATE SIGNED <u>Jan 25/57</u>			
ACTUAL SIGNATURE <u>Aaron H. Traum</u> M.D.			
PHYSICIAN'S NAME (Type) <u>Aaron H. Traum</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan 26</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Md.</u>		24a. REC'D BY REGISTRAR <u>1-23-57</u> 24b. REGISTRAR'S SIGNATURE <u>Bennie M. Thompson</u>	

CERTIFICATE OF DEATH

222

NAME OF DECEASED <i>John J. Smith</i>		AGE <i>65</i>		SEX <i>Male</i>		RACE <i>White</i>	
DATE OF DEATH <i>Jan 20 1957</i>		PLACE OF DEATH <i>Home</i>		CITY <i>Baltimore</i>		COUNTY <i>Harford</i>	
OCCUPATION <i>Retired</i>		EDUCATION <i>High School</i>		MARRIAGE <i>Married</i>		RELIGION <i>Catholic</i>	
CAUSE OF DEATH <i>Heart Disease</i>		MANNER OF DEATH <i>Natural</i>		IMMEDIATE CAUSE <i>Myocardial Infarction</i>		UNDERLYING CAUSE <i>Coronary Artery Disease</i>	
DATE OF BIRTH <i>Jan 10 1892</i>		PLACE OF BIRTH <i>Baltimore</i>		CITY <i>Baltimore</i>		COUNTY <i>Harford</i>	
OCCUPATION <i>Teacher</i>		EDUCATION <i>College</i>		MARRIAGE <i>Married</i>		RELIGION <i>Catholic</i>	
CAUSE OF DEATH <i>Heart Disease</i>		MANNER OF DEATH <i>Natural</i>		IMMEDIATE CAUSE <i>Myocardial Infarction</i>		UNDERLYING CAUSE <i>Coronary Artery Disease</i>	
DATE OF BIRTH <i>Jan 10 1892</i>		PLACE OF BIRTH <i>Baltimore</i>		CITY <i>Baltimore</i>		COUNTY <i>Harford</i>	
OCCUPATION <i>Teacher</i>		EDUCATION <i>College</i>		MARRIAGE <i>Married</i>		RELIGION <i>Catholic</i>	

RECEIVED
JAN 25 1957
BUREAU Y. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

820 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00798

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c. LENGTH OF STAY IN 1b 15 yrs.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 9212 LONG BRANCH PARKWAY				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 SILVER SPRING			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First RAY Middle F. Last FEHRMAN				4. DATE OF DEATH Month JAN Day 4 Year 19 57			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JULY 7, 1906	
9. AGE (In years last birthday) 50 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SENIOR COUNSELLOR #				10b. KIND OF BUSINESS OR INDUSTRY HIGH SCHOOL BETHESDA-CHEVY CHASE			
11. BIRTHPLACE (State or foreign country) CINCINNATI, OHIO				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME JOHN FEHRMAN				14. MOTHER'S MAIDEN NAME KATE RICKEL			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 402-38-3574		17. INFORMANT Mrs. Ernestine H. Fehrman, 9212 Long Branch Pkwy Silver Spring, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Cornary occlusion Sudden DUE TO Conditions, if any, which gave rise to immediate cause (b) 420.1 (c) 420.1 DUE TO (a) 420.1 (b) 420.1 (c) 420.1							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Frank J. Broschart M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) FRANK J. BROSCART				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL, OR DISPOSITION TRANS. & BURIAL		22b. DATE THEREOF 1/7/57		22c. NAME OF CEMETERY OR CREMATORY ARLINGTON MEM. PARK CEMETERY		22d. LOCATION (City, town, or county) (State) CINCINNATI, OHIO	
23. FUNERAL DIRECTOR'S SIGNATURE Walter B. Humphrey				ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR 1-8-57	
				24b. REGISTRAR'S SIGNATURE James Potter			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00799

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>			c. LENGTH OF STAY IN 1b 		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3215 McComas Ave.</u>				d. STREET ADDRESS <u>3215 McComas Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>FLOYD</u> Middle <u>ROOSEVELT</u> Last <u>FUNKHOUSER</u>				4. DATE OF DEATH Month <u>Jan.</u> Day <u>20</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 22, 1907</u>	
9. AGE (In years last birthday) <u>49</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Wash. San. Comm.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Clerk</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
13. FATHER'S NAME <u>THOMAS FUNKHOUSER</u>				14. MOTHER'S MAIDEN NAME <u>SARAH MOOMAN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>578-10-5352</u>		17. INFORMANT <u>ELLA A. FUNKHOUSER</u>		Address <u>#ITEM #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u> </div> <div style="width: 15%;"> INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschart</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>JAN. 20. 1957</u>	
EXAMINER'S NAME (Type) <u>DR. FRANK J. BROSCHART</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/23/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>George Wash. Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Georges Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Md.</u>				24a. REC'D BY REGISTRAR <u>DATE 1-23-57</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

JAN 25 1957

BUREAU V. S.

MAINE STATE DEPARTMENT OF HEALTH - BATHING 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED: [illegible]
RESIDENCE: [illegible]
DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE OF EXAMINER: [illegible]
OFFICE OF EXAMINER: [illegible]

100-1-1000

831
CERTIFICATE OF DEATH

Reg. Dist. No. 218

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>13 hrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Suburban Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>BERNARD</u> Middle <u>Richard</u> Last <u>GANNON</u>		4. DATE OF DEATH Month <u>JAN</u> Day <u>28</u> Year <u>1957</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 18, 77</u>
9. AGE (In years last birthday) <u>79</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Grocer</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Timothy Gannon</u>		14. MOTHER'S MAIDEN NAME <u>Anna C. McRooey</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Wife - above</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Decompensation</u> <u>541.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO (c) <u>Hemorrhage from duodenal ulcer</u>			INTERVAL BETWEEN ONSET AND DEATH <u>about 1 yr</u> <u>5-8 yrs</u> <u>2 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from _____, 19 <u>46</u> to <u>28 Jan</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>28 Jan</u> , 19 <u>57</u> , and that death occurred at <u>10:45 PM</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>William D. Aud</u> M.D. <u>9006 Glenview Rd</u> <u>28 Jan '57</u> PHYSICIAN'S NAME (Type) <u>William D. Aud</u> <u>Silver Spring</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1/31/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>	22d. LOCATION (City, town, or county) _____ (State) _____ <u>Washington, D. C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey</u>		24a. REC'D BY REGISTRAR DATE <u>1-31-57</u>	24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>JOHN ALBERT</i>		2. SEX <i>MALE</i>		3. AGE <i>68</i>	
4. DATE OF DEATH <i>FEB 1 1957</i>		5. TIME OF DEATH <i>10:00 AM</i>		6. PLACE OF DEATH <i>HOME</i>	
7. CAUSE OF DEATH <i>HEART DISEASE</i>		8. MANNER OF DEATH <i>NATURAL</i>		9. SIGNATURE OF PHYSICIAN <i>[Signature]</i>	
10. SIGNATURE OF REGISTRAR <i>[Signature]</i>		11. SIGNATURE OF CLERK <i>[Signature]</i>		12. SIGNATURE OF WITNESS <i>[Signature]</i>	
13. SIGNATURE OF DECEASED <i>[Signature]</i>		14. SIGNATURE OF NEXT OF KIN <i>[Signature]</i>		15. SIGNATURE OF BURIAL OFFICER <i>[Signature]</i>	
16. SIGNATURE OF CHURCH OFFICER <i>[Signature]</i>		17. SIGNATURE OF MINISTER <i>[Signature]</i>		18. SIGNATURE OF RABBI <i>[Signature]</i>	
19. SIGNATURE OF OTHER OFFICIAL <i>[Signature]</i>		20. SIGNATURE OF OTHER OFFICIAL <i>[Signature]</i>		21. SIGNATURE OF OTHER OFFICIAL <i>[Signature]</i>	
22. SIGNATURE OF OTHER OFFICIAL <i>[Signature]</i>		23. SIGNATURE OF OTHER OFFICIAL <i>[Signature]</i>		24. SIGNATURE OF OTHER OFFICIAL <i>[Signature]</i>	
25. SIGNATURE OF OTHER OFFICIAL <i>[Signature]</i>		26. SIGNATURE OF OTHER OFFICIAL <i>[Signature]</i>		27. SIGNATURE OF OTHER OFFICIAL <i>[Signature]</i>	
28. SIGNATURE OF OTHER OFFICIAL <i>[Signature]</i>		29. SIGNATURE OF OTHER OFFICIAL <i>[Signature]</i>		30. SIGNATURE OF OTHER OFFICIAL <i>[Signature]</i>	
31. SIGNATURE OF OTHER OFFICIAL <i>[Signature]</i>		32. SIGNATURE OF OTHER OFFICIAL <i>[Signature]</i>		33. SIGNATURE OF OTHER OFFICIAL <i>[Signature]</i>	
34. SIGNATURE OF OTHER OFFICIAL <i>[Signature]</i>		35. SIGNATURE OF OTHER OFFICIAL <i>[Signature]</i>		36. SIGNATURE OF OTHER OFFICIAL <i>[Signature]</i>	
37. SIGNATURE OF OTHER OFFICIAL <i>[Signature]</i>		38. SIGNATURE OF OTHER OFFICIAL <i>[Signature]</i>		39. SIGNATURE OF OTHER OFFICIAL <i>[Signature]</i>	
40. SIGNATURE OF OTHER OFFICIAL <i>[Signature]</i>		41. SIGNATURE OF OTHER OFFICIAL <i>[Signature]</i>		42. SIGNATURE OF OTHER OFFICIAL <i>[Signature]</i>	
43. SIGNATURE OF OTHER OFFICIAL <i>[Signature]</i>		44. SIGNATURE OF OTHER OFFICIAL <i>[Signature]</i>		45. SIGNATURE OF OTHER OFFICIAL <i>[Signature]</i>	
46. SIGNATURE OF OTHER OFFICIAL <i>[Signature]</i>		47. SIGNATURE OF OTHER OFFICIAL <i>[Signature]</i>		48. SIGNATURE OF OTHER OFFICIAL <i>[Signature]</i>	
49. SIGNATURE OF OTHER OFFICIAL <i>[Signature]</i>		50. SIGNATURE OF OTHER OFFICIAL <i>[Signature]</i>		51. SIGNATURE OF OTHER OFFICIAL <i>[Signature]</i>	
52. SIGNATURE OF OTHER OFFICIAL <i>[Signature]</i>		53. SIGNATURE OF OTHER OFFICIAL <i>[Signature]</i>		54. SIGNATURE OF OTHER OFFICIAL <i>[Signature]</i>	
55. SIGNATURE OF OTHER OFFICIAL <i>[Signature]</i>		56. SIGNATURE OF OTHER OFFICIAL <i>[Signature]</i>		57. SIGNATURE OF OTHER OFFICIAL <i>[Signature]</i>	
58. SIGNATURE OF OTHER OFFICIAL <i>[Signature]</i>		59. SIGNATURE OF OTHER OFFICIAL <i>[Signature]</i>		60. SIGNATURE OF OTHER OFFICIAL <i>[Signature]</i>	
61. SIGNATURE OF OTHER OFFICIAL <i>[Signature]</i>		62. SIGNATURE OF OTHER OFFICIAL <i>[Signature]</i>		63. SIGNATURE OF OTHER OFFICIAL <i>[Signature]</i>	
64. SIGNATURE OF OTHER OFFICIAL <i>[Signature]</i>		65. SIGNATURE OF OTHER OFFICIAL <i>[Signature]</i>		66. SIGNATURE OF OTHER OFFICIAL <i>[Signature]</i>	
67. SIGNATURE OF OTHER OFFICIAL <i>[Signature]</i>		68. SIGNATURE OF OTHER OFFICIAL <i>[Signature]</i>		69. SIGNATURE OF OTHER OFFICIAL <i>[Signature]</i>	
70. SIGNATURE OF OTHER OFFICIAL <i>[Signature]</i>		71. SIGNATURE OF OTHER OFFICIAL <i>[Signature]</i>		72. SIGNATURE OF OTHER OFFICIAL <i>[Signature]</i>	
73. SIGNATURE OF OTHER OFFICIAL <i>[Signature]</i>		74. SIGNATURE OF OTHER OFFICIAL <i>[Signature]</i>		75. SIGNATURE OF OTHER OFFICIAL <i>[Signature]</i>	
76. SIGNATURE OF OTHER OFFICIAL <i>[Signature]</i>		77. SIGNATURE OF OTHER OFFICIAL <i>[Signature]</i>		78. SIGNATURE OF OTHER OFFICIAL <i>[Signature]</i>	
79. SIGNATURE OF OTHER OFFICIAL <i>[Signature]</i>		80. SIGNATURE OF OTHER OFFICIAL <i>[Signature]</i>		81. SIGNATURE OF OTHER OFFICIAL <i>[Signature]</i>	
82. SIGNATURE OF OTHER OFFICIAL <i>[Signature]</i>		83. SIGNATURE OF OTHER OFFICIAL <i>[Signature]</i>		84. SIGNATURE OF OTHER OFFICIAL <i>[Signature]</i>	
85. SIGNATURE OF OTHER OFFICIAL <i>[Signature]</i>		86. SIGNATURE OF OTHER OFFICIAL <i>[Signature]</i>		87. SIGNATURE OF OTHER OFFICIAL <i>[Signature]</i>	
88. SIGNATURE OF OTHER OFFICIAL <i>[Signature]</i>		89. SIGNATURE OF OTHER OFFICIAL <i>[Signature]</i>		90. SIGNATURE OF OTHER OFFICIAL <i>[Signature]</i>	
91. SIGNATURE OF OTHER OFFICIAL <i>[Signature]</i>		92. SIGNATURE OF OTHER OFFICIAL <i>[Signature]</i>		93. SIGNATURE OF OTHER OFFICIAL <i>[Signature]</i>	
94. SIGNATURE OF OTHER OFFICIAL <i>[Signature]</i>		95. SIGNATURE OF OTHER OFFICIAL <i>[Signature]</i>		96. SIGNATURE OF OTHER OFFICIAL <i>[Signature]</i>	
97. SIGNATURE OF OTHER OFFICIAL <i>[Signature]</i>		98. SIGNATURE OF OTHER OFFICIAL <i>[Signature]</i>		99. SIGNATURE OF OTHER OFFICIAL <i>[Signature]</i>	
100. SIGNATURE OF OTHER OFFICIAL <i>[Signature]</i>		101. SIGNATURE OF OTHER OFFICIAL <i>[Signature]</i>		102. SIGNATURE OF OTHER OFFICIAL <i>[Signature]</i>	

BUREAU V. S.

FEB 1 1957

RECEIVED

766

CERTIFICATE OF DEATH

Reg. Dist. No.

00801

223

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE _____ b. COUNTY _____			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park				c. LENGTH OF STAY IN 1b 6 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium & Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 47x-3 District of Columbia			
f. STREET ADDRESS 1110 Aspen Street N. W.				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Leo Middle (None) Last Garner				4. DATE OF DEATH Month January Day 20 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-8-88		9. AGE (In years last birthday) 68 yrs.	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman (Retired)		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Europe		12. CITIZEN OF WHAT COUNTRY? America	
13. FATHER'S NAME Lewis Garner				14. MOTHER'S MAIDEN NAME Fannie ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -----		17. INFORMANT Hospital Records		Address _____	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Embolus 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Auricular Fibrillation DUE TO (c) Endocarditis in Heart Disease						INTERVAL BETWEEN ONSET AND DEATH 7 days 3 years 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from 1/13 , 19 57 , to 1/20 , 19 57 , that I last saw the deceased alive on 1/19 , 19 57 , and that death occurred at 3:45 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE Alvin I Kay M.D. 1835 Eye St NW Wash 1/20/57 PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, or other disposal (Specify)		22b. DATE THEREOF 1/22/57		22c. NAME OF CEMETERY OR CREMATORY CONAI BEACH CEM CRESTHILL MD		22d. LOCATION (City, town, or county) _____ (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE Calhoun		ADDRESS Funeral Home 4217-9th St. NW DC		24a. REC'D BY REGISTRAR DATE 1/22/57		24b. REGISTRAR'S SIGNATURE J. Hubert Dodd	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

IAN 23 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

767 CERTIFICATE OF DEATH

00802

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges County	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Georges County	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7300 Baltimore Ave.		d. STREET ADDRESS 2609 Fairlawn St. 16X22	
3. NAME OF DECEASED (Type or print) First HELEN Middle R. Last GIBBONS		4. DATE OF DEATH Month Jan. Day 15, Year 1957	
5. SEX Fe	6. COLOR OR RACE Wh	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 3, 1897
9. AGE (In years last birthday) 59 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W.		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) Iowa		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Joseph Rogell		14. MOTHER'S MAIDEN NAME Sda May	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 577-30-7235	
17. INFORMANT Augustus Gibbons		Address 1129 N.H.Ave. N.W.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis (bones - liver) 170x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of breast DUE TO (c) —			INTERVAL BETWEEN ONSET AND DEATH 14yrs. 11yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY o. p. m. 19 Month, Day, Year		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April , 19 56 , to Jan. 15 , 19 57 , that I last saw the deceased alive on Jan 15 , 19 57 , and that death occurred at 2:45 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Paul N. Taylor		DATE SIGNED 2-14-57	
PHYSICIAN'S NAME (Type) PAUL N. TAYLOR M.D.		ADDRESS (Street, city or town, state) Pa. Ave. N.W. Wash D.C.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/18/57	22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l. Cem.	22d. LOCATION (City, town, or county) (State) Arlington, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Burke's line		24a. REC'D BY REGISTRAR 1/16/57	
ADDRESS 1756 Pa.Ave.NW, DC		24b. REGISTRAR'S SIGNATURE J. Wilson Dodd	

CERTIFICATE OF DEATH

NAME OF DECEASED JAMES H. WILSON		DATE OF DEATH JAN 17 1957	
PLACE OF DEATH BALTIMORE, MD.		AGE 68	
OCCUPATION RETIRED		CAUSE OF DEATH HEART DISEASE	
MANNER OF DEATH NATURAL		SIGNATURE OF PHYSICIAN J. H. WILSON	
DATE OF BURIAL JAN 17 1957		PLACE OF BURIAL BALTIMORE, MD.	
NAME OF FUNERAL HOME J. H. WILSON		NAME OF MINISTER J. H. WILSON	
NAME OF NEXT OF KIN J. H. WILSON		NAME OF WITNESS J. H. WILSON	
NAME OF REGISTRAR J. H. WILSON		NAME OF CLERK J. H. WILSON	
NAME OF ASSISTANT CLERK J. H. WILSON		NAME OF CHIEF CLERK J. H. WILSON	
NAME OF DEPUTY CHIEF CLERK J. H. WILSON		NAME OF RECORDS CLERK J. H. WILSON	
NAME OF FILE CLERK J. H. WILSON		NAME OF INDEX CLERK J. H. WILSON	
NAME OF STENOGRAPHER J. H. WILSON		NAME OF TYPEWRITER J. H. WILSON	
NAME OF CLERICAL ASSISTANT J. H. WILSON		NAME OF RECEPTIONIST J. H. WILSON	
NAME OF MAIL CLERK J. H. WILSON		NAME OF TELEPHONE CLERK J. H. WILSON	
NAME OF NIGHT CLERK J. H. WILSON		NAME OF PORTER J. H. WILSON	
NAME OF JANITOR J. H. WILSON		NAME OF GROUNDSKEEPER J. H. WILSON	
NAME OF PEON J. H. WILSON		NAME OF LABORER J. H. WILSON	
NAME OF MESSENGER J. H. WILSON		NAME OF DRIVER J. H. WILSON	
NAME OF TRUCK DRIVER J. H. WILSON		NAME OF BUS DRIVER J. H. WILSON	
NAME OF TAXI DRIVER J. H. WILSON		NAME OF RENTAL CAR DRIVER J. H. WILSON	
NAME OF TRUCK DRIVER J. H. WILSON		NAME OF BUS DRIVER J. H. WILSON	
NAME OF TAXI DRIVER J. H. WILSON		NAME OF RENTAL CAR DRIVER J. H. WILSON	

BUREAU V. S.

JAN 17 1957

RECEIVED

Handwritten signature

INSTRUCTIONS

1 TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be completed within 24 hours after death. The attending physician or hospital may retain a copy of the certificate.

2 TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

00803

Reg. Dist. No. 216

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Florida</u>	COUNTY <u>Dade</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	LENGTH OF STAY (in this place) <u>8:00 pm 1/23/57</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Miami Beach</u>	TOWN <u>Miami Beach</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hospital</u>	STREET ADDRESS <u>5130 LaGorce Drive</u>	(If rural give location) <u>4545 Corn Ave NW</u>	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) <u>MRS. EDNA L.</u> (Middle) <u>GIBSON</u> (Last)		(Month) <u>Jan</u> (Day) <u>24</u> (Year) <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>5-28-91</u>
9. AGE last birthday <u>65</u> yrs.		10. IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Walter J. Gearing</u>		14. MOTHER'S MAIDEN NAME <u>Ellen Kitchenman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT & ADDRESS <u>Edythe Parah 4545 Corn Ave NW Wash DC</u>		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
331X IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>		<u>4-5 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertension</u>		<u>15-18 yrs</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Bronchitis, acute</u>		<u>5-6 days</u>	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	
21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>1946</u> , to <u>24 Jan</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>23 Jan</u> , 19 <u>57</u> , and that death occurred at <u>7:00 AM</u> , from the causes and on the date stated above.			
SIGNATURE <u>William D. Caud</u>		DATE SIGNED <u>1/24/57</u>	
ADDRESS (Street, city, town, state) <u>9006 Lakeside Rd. S.W. S.W.</u>		LOCATION (City, town, or county) (State) <u>Miami Beach, Florida</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Ship & burial</u>		DATE THEREOF <u>Jan. 28, 1957</u>	
NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>		24. REC'D BY REGISTRAR <u>Bessie M. Thompson</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey Inc.</u>		ADDRESS <u>8434 Georgia Ave S.W. Spring Mt.</u>	

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

A. NAME OF DECEASED

B. SEX

C. AGE

D. DATE OF BIRTH

E. PLACE OF BIRTH

F. OCCUPATION

G. CAUSE OF DEATH

H. PLACE OF DEATH

I. DATE OF DEATH

J. SIGNATURE OF PHYSICIAN

K. SIGNATURE OF REGISTRAR

L. SIGNATURE OF WITNESSES

M. SIGNATURE OF DECEASED

N. SIGNATURE OF NEAREST RELATIVE

O. SIGNATURE OF CLERGYMAN

P. SIGNATURE OF CHURCH

Q. SIGNATURE OF BURIAL PLACE

R. SIGNATURE OF FUNERAL HOME

S. SIGNATURE OF CEMETERY

T. SIGNATURE OF INTERVIEWER

U. SIGNATURE OF INTERVIEWER

V. SIGNATURE OF INTERVIEWER

W. SIGNATURE OF INTERVIEWER

X. SIGNATURE OF INTERVIEWER

Y. SIGNATURE OF INTERVIEWER

Z. SIGNATURE OF INTERVIEWER

AA. SIGNATURE OF INTERVIEWER

AB. SIGNATURE OF INTERVIEWER

AC. SIGNATURE OF INTERVIEWER

AD. SIGNATURE OF INTERVIEWER

AE. SIGNATURE OF INTERVIEWER

AF. SIGNATURE OF INTERVIEWER

AG. SIGNATURE OF INTERVIEWER

AH. SIGNATURE OF INTERVIEWER

AI. SIGNATURE OF INTERVIEWER

AJ. SIGNATURE OF INTERVIEWER

AK. SIGNATURE OF INTERVIEWER

AL. SIGNATURE OF INTERVIEWER

AM. SIGNATURE OF INTERVIEWER

AN. SIGNATURE OF INTERVIEWER

AO. SIGNATURE OF INTERVIEWER

AP. SIGNATURE OF INTERVIEWER

AQ. SIGNATURE OF INTERVIEWER

AR. SIGNATURE OF INTERVIEWER

AS. SIGNATURE OF INTERVIEWER

AT. SIGNATURE OF INTERVIEWER

AU. SIGNATURE OF INTERVIEWER

AV. SIGNATURE OF INTERVIEWER

AW. SIGNATURE OF INTERVIEWER

AX. SIGNATURE OF INTERVIEWER

AY. SIGNATURE OF INTERVIEWER

AZ. SIGNATURE OF INTERVIEWER

BA. SIGNATURE OF INTERVIEWER

BB. SIGNATURE OF INTERVIEWER

BC. SIGNATURE OF INTERVIEWER

BD. SIGNATURE OF INTERVIEWER

BE. SIGNATURE OF INTERVIEWER

BF. SIGNATURE OF INTERVIEWER

BG. SIGNATURE OF INTERVIEWER

BH. SIGNATURE OF INTERVIEWER

BI. SIGNATURE OF INTERVIEWER

BUREAU V. S.

JAN 29 1957

RECEIVED

833
CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SPENCERVILLE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SPENCERVILLE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>A</u> Last <u>Gibson</u>				4. DATE OF DEATH Month <u>JAN</u> Day <u>17</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN 28, 1898</u>		9. AGE (In years last birthday) yrs. <u>61</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>GEN. CARPENTERING</u>		11. BIRTHPLACE (State or foreign country) <u>SPENCERVILLE, MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOHN M. GIBSON</u>				14. MOTHER'S MAIDEN NAME <u>ANNIE ELIZA PIERCE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>219-07-9383</u>		17. INFORMANT <u>MRS. BESSIE GIBSON</u> Address <u>SPENCERVILLE, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lymphosarcoma</u> <u>200.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u> </u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>JAN</u> , 19 <u>52</u> , to <u>JAN</u> , 19 <u>52</u> , that I last saw the deceased alive on <u>JAN 16</u> , 19 <u>52</u> , and that death occurred at <u>11:00</u> A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>A. D. Bonifant</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>Sandy Spring, Md. 4/19/57</u>			
PHYSICIAN'S NAME (Type) <u>A. D. BONIFANT</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>JAN 19, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Union Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Spencerville - Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur D. Hall</u>				ADDRESS <u>254 Carroll St. NW.</u>		24a. REC'D BY REGISTRAR <u>JAN 18 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Gertrude Lowery</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

834

CERTIFICATE OF DEATH

Reg. Dist. No.

00805
216

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Maryland		c. LENGTH OF STAY IN 1b 84 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Kensington	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS 3210 Edgewood Road	
3. NAME OF DECEASED (Type or print) First Richard Middle Winston Last Giroux		4. DATE OF DEATH Month January Day 7 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 2, 1908
9. AGE (In years last birthday) 48 yrs.		IF UNDER 1 YEAR Months 11 Days 00 Hours 00 Min. 00	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Records Administrator		10b. KIND OF BUSINESS OR INDUSTRY Government	
11. BIRTHPLACE (State or foreign country) Michigan		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Giroux		14. MOTHER'S MAIDEN NAME Anna Boyd	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. (If you give age or dates of service) WW II	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Epidermoid carcinoma of both lungs 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) c metastases to both adrenals, both DUE TO (c) kidneys and multiple bones INTERVAL BETWEEN ONSET AND DEATH 11 mos.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour 01 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 15, 1956 to January 7, 1957 , that I last saw the deceased alive on January 7, 1957 , and that death occurred at 11:22AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Edward J. Laskowski M.D.		ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland	
DATE SIGNED 1/7/57			
PHYSICIAN'S NAME (Type) Edward J. Laskowski, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-10-57	
22c. NAME OF CEMETERY OR CREMATORY Arlington Nat. Cem		22d. LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda Md	
24a. REC'D BY REGISTRAR 1-8-57		24b. REGISTRAR'S SIGNATURE Theresa M. Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 6 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00806

835

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 40 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Maryland				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Eleanor Middle Portch Last GOODMAN				4. DATE OF DEATH Month January Day 31 Year 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 23 Sept. 1889	
9. AGE (In years last birthday) 67 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Eason PORTCH		14. MOTHER'S MAIDEN NAME Lucy TURNER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 226 18 4300		17. INFORMANT (Son) Boris N. Goodman (Same As #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma, Cervix with metastases 171X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH unknown							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. 1 p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 22 Nov. , 19 56 , to 31 Jan. , 19 57 , that I last saw the deceased alive on 30 Jan. , 19 57 , and that death occurred at 1:21A. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Arthur J. Johnson M.D. U.S. Naval Hospital, Bethesda, Md. 1-31-57 PHYSICIAN'S NAME (Type) Arthur J. Johnson, LT, MC, USN U.S. Naval Hospital, Bethesda, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-4-57		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Humphrey ADDRESS 1557 Wisconsin Ave., Bethesda, Md.				24a. REC'D BY REGISTRAR 1-31-57 24b. REGISTRAR'S SIGNATURE Barry E. Russell			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

Name of Deceased J. H. HARRIS, JR.		Sex Male		Age 38	
Date of Birth 1929		Place of Birth Baltimore, Maryland		Usual Residence Baltimore, Maryland	
Cause of Death Heart Disease		Date of Death Feb. 4, 1967		Place of Death Home	
Occupation Engineer		Marital Status Married		Signature of Physician J. H. HARRIS, JR.	
Signature of Informant J. H. HARRIS, JR.		Relationship to Deceased Son		Signature of Registrar J. H. HARRIS, JR.	
Manner of Death Natural		Certification of Death I hereby certify that the above is a true and correct statement of the facts as to the death of the above named person.		Date of Certification Feb. 4, 1967	
Signature of Registrar J. H. HARRIS, JR.		Signature of Informant J. H. HARRIS, JR.		Signature of Physician J. H. HARRIS, JR.	
Signature of Informant J. H. HARRIS, JR.		Signature of Physician J. H. HARRIS, JR.		Signature of Registrar J. H. HARRIS, JR.	

BUREAU V. S.

FEB 4, 1967

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00807

836

CERTIFICATE OF DEATH

Reg. Dist. No.

2116

1. PLACE OF DEATH a. COUNTY <u>MONT GOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>MONT GOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				d. STREET ADDRESS <u>110002 Forest Grove Drive</u>			
3. NAME OF DECEASED (Type or print) First <u>GRACE</u> Middle <u>Theresa</u> Last <u>GRANT</u>				4. DATE OF DEATH Month <u>1</u> Day <u>10</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10/18/83</u>	
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months <u>2</u> Days <u>22</u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>- - - - -</u>		11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>	
13. FATHER'S NAME <u>John C. Dougherty</u>				14. MOTHER'S MAIDEN NAME <u>Helen Hamilton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Husband - spouse</u> Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Postoperative shock</u> <u>175x</u> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause (c), stating the underlying cause last. (b) <u>Intraabdominal Hemorrhage</u> (c) <u>Solid Carcinoma of the Ovary, Bilateral.</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>June 1953</u> to <u>June 10, 1957</u> , that I last saw the deceased alive on <u>June 10, 1957</u> , and that death occurred at <u>8 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Philip A. Caulfield</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>Philip A. Caulfield, M.D.</u>				2701 Conn. Ave. N. W., Wash. D. C.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/14/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-7557 Wis. Ave. Beth. Md.</u>				ADDRESS		24a. REC'D BY REGISTRAR <u>DATE 12-57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>			

CERTIFICATE OF DEATH

Form with multiple fields for death certificate information, including name, date, and location. The text is mostly illegible due to blurriness.

BUREAU V. S.

JAN 15 1957

RECEIVED

Form with fields for signature, date, and other administrative information. The text is mostly illegible due to blurriness.

CERTIFICATE OF DEATH

Item 18 Film 210 2-4-57 ans

b. COUNTY Polk

limits, write RURAL and give nearest town)

e. IS RESIDENCE ON A FARM?
YES ☐ NO ☒

Day 19 Year 19

IF UNDER 24 HRS.	
Hours	Min.

12. CITIZEN OF WHAT COUNTRY?

Esther Badt

Address

INTERVAL BETWEEN ONSET AND DEATH

(c)

19. WAS AUTOPSY PERFORMED?
YES ☐ NO ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

(State)

DATE SIGNED _____

ADDRESS (Street, city or town, state) DATE SIGNED

2412 Colston Dr Silver Spring, Md 1/19/5

MAYNARDI, COHEN

(State)

24b. REGISTRAR'S SIGNATURE

DATE 2 2 1957

J. Wilson Radd

VS AIS (4)
15M 9/SS

RECEIVED

JAN 22 1957

BUREAU V. S.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 10

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00809

CERTIFICATE OF DEATH

Reg. Dist. No.

213

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> <u>Rockville Md</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	c. LENGTH OF STAY IN 1b <u>26</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>106 Lynch St.</u>		d. STREET ADDRESS <u>106 Lynch St.</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Bertha</u> Middle <u>Grossman</u> Last <u>Grossman</u>		4. DATE OF DEATH Month <u>May</u> Day <u>5</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 5, 1900</u>
9. AGE (In years last birthday) <u>56</u> yrs.		10. IF UNDER 1 YEAR Months <u>5</u> Days <u>18</u> Hours <u>10</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (State or foreign country) <u>Russia</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Lazer Chelick</u>	
14. MOTHER'S MAIDEN NAME <u>Reba</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Samuel Grossman - Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> <u>332x</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Generalized arteriosclerosis</u> cause (c) <u>260x</u> DUE TO lying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus, Caprine, Toes</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Sept 1954</u> to <u>Jan 1957</u> , that I last saw the deceased alive on <u>Jan 1957</u> , and that death occurred at <u>11:00 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>H. C. Chapman</u> M.D.		DATE SIGNED <u>7 Crothers Ct. Rockville Md</u>	
PHYSICIAN'S NAME (Type) <u>H. C. Chapman</u>		ADDRESS <u>7 Crothers Ct. Rockville Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>Jan 7/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Anshei Emunah</u>	22d. LOCATION (City, town, or county) (State) <u>Balto, Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Sol Feinson</u>		ADDRESS <u>1124-26 W. North Ave</u>	24a. REC'D BY REGISTRAR <u>JAN 9 1957</u>
24b. REGISTRAR'S SIGNATURE <u>Laurell Hightower</u>			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALT. CH. 10

BUREAU V. 3

JAN 9 1957

RECEIVED

1

INSTRUCTIONS

TO A BOUNDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be filed within 24 hours after death. The death certificate may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

788

CERTIFICATE OF DEATH

00810

Reg. Dist. No. 276

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>DC</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Waverly Sanatorium</u>				STREET ADDRESS (If rural give location) <u>5401 16th Street NW</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Mary</u> (Middle) <u>E.</u> (Last) <u>Guy</u>				(Month) <u>Jan</u> (Day) <u>9</u> (Year) <u>1957</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>Widowed</u>	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>		<u>Oct 5, 1857</u>	<u>99</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Alexander Bohrer</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Otterback</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>5401 16th St NW</u> <u>Walter B. Guy Washington, DC</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Branchopneumonia</u>						<u>4 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Chronic passive congestion</u>						<u>2 wks</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>myocardial failure</u>						<u>2 wks</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Generalised arteriosclerosis</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 9, 1957</u> , to <u>Jan 9, 1957</u> , that I last saw the deceased alive on <u>Jan 9, 1957</u> , and that death occurred at <u>11:25 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Stewart C. Leff</u> M.D. <u>3921 Ingomar St NW</u>				ADDRESS (Street, city, town, state) <u>1756 Pennsylvania Ave NW Washington, DC</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1/12/57</u>		NAME OF CEMETERY OR CREMATORY <u>Rock Creek, Cemetery</u>		LOCATION (City, town, or county) <u>Washington DC</u>	
24. REC'D BY REGISTRAR <u>1-11-57</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph M. ...</u>		ADDRESS <u>1756 Pennsylvania Ave NW Washington, DC</u>	

RECEIVED
JAN 15 1957
BUREAU V. I.

may be retained by the hospital, or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 could be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00811

837

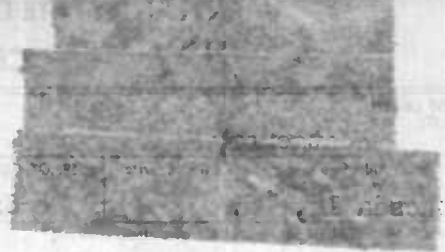
CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda 14, Md.</u>				c. LENGTH OF STAY IN 1b <u>8 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Florence</u> Middle <u>Koppelman</u> Last <u>Haines</u>				4. DATE OF DEATH Month <u>January</u> Day <u>10</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>October 6, 1915</u>	
9. AGE (In years last birthday) <u>41</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Administrative Aide</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Abraham Koppelman</u>				14. MOTHER'S MAIDEN NAME <u>Sophia Dorman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>565-38-8633</u>		17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Liver failure</u> DUE TO (b) <u>Tumor involvement of liver</u> DUE TO (c) <u>Breast cancer - widespread metastases</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. <u>170X</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Widespread bone involvement with rib fractures</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>6 mos</u> <u>8 yrs</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour <u>a. n.</u> Month <u>19</u> Day <u>19</u> Year <u>1957</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>January 2</u> , 19 <u>57</u> , to <u>January 10</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>January 10</u> , 19 <u>57</u> , and that death occurred at <u>10:20 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John Laszlo</u>				DATE SIGNED <u>1/11/57</u>			
PHYSICIAN'S NAME (Type) <u>John Laszlo, M. D.</u>				ADDRESS (Street, city or town, state) <u>The Clinical Center</u> <u>National Institutes of Health</u> <u>Bethesda 14, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>1-13-57</u>		<u>United Hebrew</u>		<u>Balto Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lewis Mc 2100 Ectaw Pl</u>				24. REC'D BY REGISTRAR <u>JAN 16 1957</u>			
25. REGISTRAR'S SIGNATURE <u>Bessie Thompson</u>							

DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH



NAME OF DECEASED [REDACTED]		SEX [REDACTED]		AGE [REDACTED]	
DATE OF BIRTH [REDACTED]		PLACE OF BIRTH [REDACTED]		RACE [REDACTED]	
DATE OF DEATH [REDACTED]		PLACE OF DEATH [REDACTED]		TIME OF DEATH [REDACTED]	
CAUSE OF DEATH [REDACTED]		MANNER OF DEATH [REDACTED]		MEDICAL HISTORY [REDACTED]	
SIGNATURE OF PHYSICIAN [REDACTED]		SIGNATURE OF REGISTRAR [REDACTED]		SIGNATURE OF WITNESS [REDACTED]	
CITY [REDACTED]		COUNTY [REDACTED]		STATE [REDACTED]	
ZIP CODE [REDACTED]		FEDERAL BUREAU OF INVESTIGATION [REDACTED]		U.S. DEPARTMENT OF JUSTICE [REDACTED]	

BUREAU V. S.

JAN 16 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

769

CERTIFICATE OF DEATH

Reg. Dist. No.

00812

214

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>17307 TAKOMA AVE</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>WEPPIE T. HAISLIP</u>		4. DATE OF DEATH Month <u>Jan</u> Day <u>28</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 22, 1976</u>
9. AGE (In years (last birthday) yrs. <u>80</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>WILLIAM T OLIVER</u>		14. MOTHER'S MAIDEN NAME <u>CATHERINE J COURTNEY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>MARGARET H. WENDLANDT</u>		Address <u>4111 E. Superior St. Duluth, Minn.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aplastic Anemia</u> <u>292.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arterio-sclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 18, 1955</u> to <u>Jan 28, 1957</u> that I last saw the deceased alive on <u>Jan 27, 1957</u> , and that death occurred at <u>6:45 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A. B. Little</u>		M.D. <u>6911 5th St. N.W.</u> DATE SIGNED <u>Jan 28/57</u>	
PHYSICIAN'S NAME (Type) <u>A. B. LITTLE MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan 31, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek</u>		22d. LOCATION (City, town, or county) (State) <u>Washington DC</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Neal Funeral Home</u>		ADDRESS <u>4812 Ga Ave NW Wash DC</u>	
24a. REC'D. BY REGISTRAR DATE <u>1/31/57</u>		24b. REGISTRAR'S SIGNATURE <u>Frances Potter</u>	

RECEIVED

may be retained by the hospital, or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

838

CERTIFICATE OF DEATH

00813

Reg. Dist. No. 212

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Germantown				c. LENGTH OF STAY IN 1b 2 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Poolesville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Marylander Rest Home				d. STREET ADDRESS 122			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Margaret M Hall				4. DATE OF DEATH Month January Day 1 Year 19 57			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 23-1976		9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Phillip Dutrow				14. MOTHER'S MAIDEN NAME Achseh Dutrow			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT John Hall, Poolesville, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) Cerebral softening DUE TO (c) Cerebral and General Arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH 10 days 4 months 5 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 2 June, 1950 , to 1 Jan, 1957 , that I last saw the deceased alive on 31 Dec, 1956 , and that death occurred at 1:35 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Gordon M. Smith				ADDRESS (Street, city or town, state) BARNESVILLE Maryland		DATE SIGNED 24 Jan 57	
PHYSICIAN'S NAME (Type) GORDON M. SMITH,							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/4/57		22c. NAME OF CEMETERY OR CREMATORY Monocacy		22d. LOCATION (City, town, or county) (State) Boallsville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE William B. Hillen, Barnesville, Md				24a. REC'D BY REGISTRAR DATE 1/4/57		24b. REGISTRAR'S SIGNATURE Charles W. Edgum per W.E.	

ARMY AND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD.

7-23-2004

579-587201

067204 5

011976

THE UNIVERSITY OF CHICAGO

10

200

2001

1994-1995

4307

John Holt, Police No. 1467

BUREAU V. S.

JAN 7 1957

RECEIVED

5000

52112

1216

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

839

CERTIFICATE OF DEATH

00814

Reg. Dist. No. 216

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Washington		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. LENGTH OF STAY IN 1b 38 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 47x3 Washington, D. C.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kensington Garden Sanitarium			d. STREET ADDRESS 3419 N St., N. W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Josephine Middle Louise Last Halloran			4. DATE OF DEATH Month Jan. Day 31st. Year 19 57		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 1883		9. AGE (In years lost birthday) 73 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington, D. C.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Theodore Horn			14. MOTHER'S MAIDEN NAME Minnie Reinhart		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Minnie Meyers 1821 Jackson St., N.E., D.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 157x Branchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Corcinoma pancreas DUE TO (c) 2 yrs.					INTERVAL BETWEEN ONSET AND DEATH 5 days.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Nat while <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Wash. D.C.	
20f. (City or town) Washington, D. C.		20g. (County) D.C.		20h. (State) D.C.	
21. I certify that I attended the deceased from April 12, 1956 , to Jan. 21, 1957 , that I last saw the deceased alive on 21 Jan , 19 57 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Washington, D.C. DATE SIGNED Charles Thompson					
ACTUAL SIGNATURE Charles Thompson M.D. Chas. Wash. D.C.					
PHYSICIAN'S NAME (Type) Charles Thompson 1714 N St., N. W., Wash., D.C.					
22a. BURIAL, CREMATION, REMOVAL (Specify) 2/2/57		22b. DATE THEREOF 2/2/57		22c. NAME OF CEMETERY OR CREMATORY Oak Hill	
22d. LOCATION (City, town, or county) Washington, D. C.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Joseph F. Burch's Son			24a. REC'D BY REGISTRAR DATE 2-2-57		
ADDRESS 3034 M St. N.W., D.C.			24b. REGISTRAR'S SIGNATURE Bennie M. Thompson		

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
JAMES EARL RAY		35		Male		White		April 14, 1928		Memphis, Tennessee		Memphis		Tennessee		United States of America	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH	
April 4, 1968		London, England		London		England		United Kingdom		April 4, 1968		London, England		London		England	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		MARRIAGE		SINGLE		MARRIED		DIVORCED	
Suicide		Suicide		Attorney		High School		Protestant		Married		Single		Married		Divorced	
DETAILS OF DEATH		DETAILS OF DEATH		DETAILS OF DEATH		DETAILS OF DEATH		DETAILS OF DEATH		DETAILS OF DEATH		DETAILS OF DEATH		DETAILS OF DEATH		DETAILS OF DEATH	
The deceased was found in his room at the London Hilton Hotel, London, England, on April 4, 1968, with a self-inflicted gunshot wound to the chest. He was found by a maid who called the police. He was pronounced dead at the scene.		The deceased was found in his room at the London Hilton Hotel, London, England, on April 4, 1968, with a self-inflicted gunshot wound to the chest. He was found by a maid who called the police. He was pronounced dead at the scene.		The deceased was found in his room at the London Hilton Hotel, London, England, on April 4, 1968, with a self-inflicted gunshot wound to the chest. He was found by a maid who called the police. He was pronounced dead at the scene.		The deceased was found in his room at the London Hilton Hotel, London, England, on April 4, 1968, with a self-inflicted gunshot wound to the chest. He was found by a maid who called the police. He was pronounced dead at the scene.		The deceased was found in his room at the London Hilton Hotel, London, England, on April 4, 1968, with a self-inflicted gunshot wound to the chest. He was found by a maid who called the police. He was pronounced dead at the scene.		The deceased was found in his room at the London Hilton Hotel, London, England, on April 4, 1968, with a self-inflicted gunshot wound to the chest. He was found by a maid who called the police. He was pronounced dead at the scene.		The deceased was found in his room at the London Hilton Hotel, London, England, on April 4, 1968, with a self-inflicted gunshot wound to the chest. He was found by a maid who called the police. He was pronounced dead at the scene.		The deceased was found in his room at the London Hilton Hotel, London, England, on April 4, 1968, with a self-inflicted gunshot wound to the chest. He was found by a maid who called the police. He was pronounced dead at the scene.		The deceased was found in his room at the London Hilton Hotel, London, England, on April 4, 1968, with a self-inflicted gunshot wound to the chest. He was found by a maid who called the police. He was pronounced dead at the scene.	

RECEIVED
FEB 5 1967
BUREAU V. 3

840

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>25 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center</u>				d. STREET ADDRESS <u>5105 Ardmore Way</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Leroy</u> Middle <u>Joseph</u> Last <u>Hart</u>				4. DATE OF DEATH Month <u>January</u> Day <u>26</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 23, 1936</u>	
9. AGE (In years last birthday) <u>20</u> yrs.		IF UNDER 1 YEAR Months <u>26</u> Days <u>19</u> Hours <u>57</u> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Instrument maker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Instrument Making</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Clayton Hart</u>				14. MOTHER'S MAIDEN NAME <u>Grace Brown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-32-6496</u>		17. INFORMANT <u>The Medical Record, Clinical Center</u> Address <u>National Institutes of Health, Bethesda 14, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral Broncho-pneumonia</u> 204.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Septicemia</u> DUE TO (c) <u>Acute myelogenous leukemia</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>1 week</u> <u>7 months</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>9</u> p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>January 1, 1957</u> , to <u>January 26, 1957</u> , that I last saw the deceased alive on <u>January 26, 1957</u> , and that death occurred at <u>5:15 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Gurston Goldin</u> M.D. <u>The Clinical Center</u>				DATE SIGNED <u>1/26/57</u>			
PHYSICIAN'S NAME (Type) <u>GURSTON GOLDIN, M. D.</u>				ADDRESS (Street, city or town, state) <u>National Institutes of Health Bethesda 14, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/29/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Moreland Mem. Park</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Rudk</u> ADDRESS <u>5305 Harford Road. #14</u>				24a. REC'D BY REGISTRAR <u>AN 29 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie Thompson</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 2 and 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

BUREAU V. 2

JAN 29 1957

RECEIVED

770

CERTIFICATE OF DEATH

Reg. Dist. No.

223

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>District Columbia</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park 12 Md.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington 47x-3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. & Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Love</u> Last <u>K. Hathaway</u>				4. DATE OF DEATH Month <u>1</u> Day <u>9</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-3-83</u>	
9. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		10. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months <u>1</u> Days <u>9</u> Hours <u>1</u> Min. <u>57</u>		IF UNDER 24 HRS. Hours <u>1</u> Min. <u>57</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Indiana</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>				13. FATHER'S NAME <u>ELBERT Kessler</u>			
14. MOTHER'S MAIDEN NAME <u>Emma Hogan</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>NONE</u>			
16. SOCIAL SECURITY NO. <u>NONE</u>				17. INFORMANT Address <u>Mr. Alvin Hathaway 3620 16th St</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331X Congestive Cardiac Failure</u> DUE TO (b) <u>Cerebral Accident</u> DUE TO (c) <u>Arteriosclerosis & Hypertension</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Inanition</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>October, 1954</u> , to <u>Jan 9, 1957</u> , that I last saw the deceased alive on <u>Jan 9, 1957</u> , and that death occurred at <u>10:15 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert A. Hare</u> M.D.				ADDRESS (Street, city or town, state) <u>Takoma Park, Md.</u> DATE SIGNED <u>1-10-57</u>			
PHYSICIAN'S NAME (Type) <u>Robert A. HARE</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>TRANS. & BURIAL</u>		22b. DATE THEREOF <u>1/12/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>OAKLAWN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>MORROCO, INDIANA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey, Inc.</u> ADDRESS <u>8434 Ga Ave. S.S. Md.</u>				24a. REC'D BY REGISTRAR <u>1/11/57</u>		24b. REGISTRAR'S SIGNATURE <u>F. Wilcox Dodd</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. PLACE OF BIRTH		5. DATE OF BIRTH		6. DATE OF DEATH	
7. PLACE OF DEATH		8. CAUSE OF DEATH		9. MANNER OF DEATH	
10. SIGNATURE OF PHYSICIAN		11. SIGNATURE OF CORONER		12. SIGNATURE OF REGISTRAR	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF WITNESS		15. SIGNATURE OF WITNESS	
16. SIGNATURE OF WITNESS		17. SIGNATURE OF WITNESS		18. SIGNATURE OF WITNESS	
19. SIGNATURE OF WITNESS		20. SIGNATURE OF WITNESS		21. SIGNATURE OF WITNESS	
22. SIGNATURE OF WITNESS		23. SIGNATURE OF WITNESS		24. SIGNATURE OF WITNESS	
25. SIGNATURE OF WITNESS		26. SIGNATURE OF WITNESS		27. SIGNATURE OF WITNESS	
28. SIGNATURE OF WITNESS		29. SIGNATURE OF WITNESS		30. SIGNATURE OF WITNESS	
31. SIGNATURE OF WITNESS		32. SIGNATURE OF WITNESS		33. SIGNATURE OF WITNESS	
34. SIGNATURE OF WITNESS		35. SIGNATURE OF WITNESS		36. SIGNATURE OF WITNESS	
37. SIGNATURE OF WITNESS		38. SIGNATURE OF WITNESS		39. SIGNATURE OF WITNESS	
40. SIGNATURE OF WITNESS		41. SIGNATURE OF WITNESS		42. SIGNATURE OF WITNESS	
43. SIGNATURE OF WITNESS		44. SIGNATURE OF WITNESS		45. SIGNATURE OF WITNESS	
46. SIGNATURE OF WITNESS		47. SIGNATURE OF WITNESS		48. SIGNATURE OF WITNESS	
49. SIGNATURE OF WITNESS		50. SIGNATURE OF WITNESS		51. SIGNATURE OF WITNESS	
52. SIGNATURE OF WITNESS		53. SIGNATURE OF WITNESS		54. SIGNATURE OF WITNESS	
55. SIGNATURE OF WITNESS		56. SIGNATURE OF WITNESS		57. SIGNATURE OF WITNESS	
58. SIGNATURE OF WITNESS		59. SIGNATURE OF WITNESS		60. SIGNATURE OF WITNESS	
61. SIGNATURE OF WITNESS		62. SIGNATURE OF WITNESS		63. SIGNATURE OF WITNESS	
64. SIGNATURE OF WITNESS		65. SIGNATURE OF WITNESS		66. SIGNATURE OF WITNESS	
67. SIGNATURE OF WITNESS		68. SIGNATURE OF WITNESS		69. SIGNATURE OF WITNESS	
70. SIGNATURE OF WITNESS		71. SIGNATURE OF WITNESS		72. SIGNATURE OF WITNESS	
73. SIGNATURE OF WITNESS		74. SIGNATURE OF WITNESS		75. SIGNATURE OF WITNESS	
76. SIGNATURE OF WITNESS		77. SIGNATURE OF WITNESS		78. SIGNATURE OF WITNESS	
79. SIGNATURE OF WITNESS		80. SIGNATURE OF WITNESS		81. SIGNATURE OF WITNESS	
82. SIGNATURE OF WITNESS		83. SIGNATURE OF WITNESS		84. SIGNATURE OF WITNESS	
85. SIGNATURE OF WITNESS		86. SIGNATURE OF WITNESS		87. SIGNATURE OF WITNESS	
88. SIGNATURE OF WITNESS		89. SIGNATURE OF WITNESS		90. SIGNATURE OF WITNESS	
91. SIGNATURE OF WITNESS		92. SIGNATURE OF WITNESS		93. SIGNATURE OF WITNESS	
94. SIGNATURE OF WITNESS		95. SIGNATURE OF WITNESS		96. SIGNATURE OF WITNESS	
97. SIGNATURE OF WITNESS		98. SIGNATURE OF WITNESS		99. SIGNATURE OF WITNESS	
100. SIGNATURE OF WITNESS		101. SIGNATURE OF WITNESS		102. SIGNATURE OF WITNESS	

RECEIVED
JAN 14 1957
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00817

Reg. Dist. No.

213

841

1. PLACE OF DEATH a. COUNTY Rockville Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville RFD #4			c. LENGTH OF STAY IN life life	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville RFD # 4			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Tilden Lane				e. STREET ADDRESS Tilden Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Rachael First Hawkins Middle Lost				4. DATE OF DEATH Month Jan Day 19 Year 1957			
5. SEX female	6. COLOR OR RACE ool.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 16, 1885		9. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework		10b. KIND OF BUSINESS OR INDUSTRY Maryland		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Wesley Green				14. MOTHER'S MAIDEN NAME Elmira Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Lilly McRoy 510 Bickford La. Rockville Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH Found dead in bed	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.							
ACTUAL SIGNATURE <i>Frank J. Broschart</i> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) Frank J. Broschart				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 1/23/57		22c. NAME OF CEMETERY OR CREMATORY Haiti	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert L. Sworden</i>				ADDRESS Rockville, Md.		24a. REC'D BY REGISTRAR DATE Jan 28 1957	
24b. REGISTRAR'S SIGNATURE <i>Laurel Longtop</i>				24c. (City or town) (County) (State)			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 1 and 2 with the Registrar prior to burial, cremation, or removal.

RECEIVED

JAN 28 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00818

Reg. Dist. No. 214

1. PLACE OF DEATH a. COUNTY MONTGOMERY 842 b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING c. LENGTH OF STAY IN 1b DOA d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) IN WOODS - MANCHESTER ROAD		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 SILVER SPRING d. STREET ADDRESS 1931 ETON ROADUE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First GEORGETTE Middle ANNE Last HENTGEN		4. DATE OF DEATH Month JAN. Day 14 Year 19 57									
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> SEPT. 10, 1941									
9. AGE (In years last birthday) 15 yrs. <table border="1" style="display: inline-table; vertical-align: top;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STUDENT 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) MICHIGAN 12. CITIZEN OF WHAT COUNTRY? U.S.A.	
IF UNDER 1 YEAR		IF UNDER 24 HRS.									
Months	Days	Hours	Min.								
13. FATHER'S NAME JOHN R. HENTGEN		14. MOTHER'S MAIDEN NAME GRACE OTIS									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 17. INFORMANT POLICE RECORDS, SILVER SPRING, MARYLAND Address									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE AND CONTUSION DUE TO 983X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) FRACTURE OF SKULL (rt) DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) undertermined									
20c. TIME OF INJURY Month, Day, Year Hour 1/14 57 a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) unknown		20f. (City or town) Silver Spring, Montgomery, Md. (County) (State)									
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined cause <input type="checkbox"/>											
ACTUAL SIGNATURE <i>Frank J. Broschart</i> EXAMINER'S NAME (Type) Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>									
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 22b. DATE THEREOF 1/18/57		22c. NAME OF CEMETERY OR CREMATORY PARKLAWN CEMETERY 22d. LOCATION (City, town, or county) MONTGOMERY COUNTY, MARYLAND (State)									
23. FUNERAL DIRECTOR'S SIGNATURE <i>Warner C. Humphrey</i> ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR 1/17/57 DATE									
24b. REGISTRAR'S SIGNATURE <i>Frances Potter</i>		DATE SIGNED 1/15/57									

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be furnished to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 2

JAN 21 1957

RECEIVED

843

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore Bethesda				c. LENGTH OF STAY IN 1b 2 1/2 Mo.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle Joseph Last HIGGINS				4. DATE OF DEATH Month Jan Day 1 Year 19 57			
5. SEX Male		6. COLOR OR RACE Cauc		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 20; 98	
9. AGE (In years last birthday) 58 5/11 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner				10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy		11. BIRTHPLACE (State or foreign country) Connecticut	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME John Joseph HIGGINS				14. MOTHER'S MAIDEN NAME Helen BURKE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW1 WW11				16. SOCIAL SECURITY NO. 7 11 05 81 49			
17. INFORMANT 621 N. Montford Ave. Baltimore, Md. Mrs. John D. HIGGINS (Wife)							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lymphosarcoma DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 200.1 DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH Year & half	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 1 Jan 19 57 , to 1 Jan 19 57 , that I last saw the deceased alive on 1 Jan 19 57 , and that death occurred at 0645 M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Baltimore, Maryland DATE SIGNED 1-1-57 ACTUAL SIGNATURE Biagio A. Conte M.D. U. S. Naval Hospital, Bethesda, Md. PHYSICIAN'S NAME (Type) Biagio A. CONTE							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-5-57		22c. NAME OF CEMETERY OR CREMATORY Oaklawn		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John A. MILLER 2334 Jefferson St., Baltimore, Md.				24a. REC'D BY REGISTRAR Mary E. Carvelly		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

LOCALITY OF DEATH		DATE OF DEATH	
BALTIMORE		JAN 4 1967	
DECEASED'S NAME		SEX	
JOHN J. HENNING		M	
AGE		DATE OF BIRTH	
70		JAN 10 1896	
MARRIAGE		SPOUSE'S NAME	
MARRIED		JOHN J. HENNING	
OCCUPATION		EDUCATION	
Carpenter		High School	
PLACE OF BIRTH		CITY OF BIRTH	
BALTIMORE, MD.		BALTIMORE, MD.	
CAUSE OF DEATH		MANNER OF DEATH	
Myocardial Infarction		Natural	
IMMEDIATE CAUSE		UNDERLYING CAUSE	
Myocardial Infarction		Myocardial Infarction	
INTERVIEWED BY		DATE OF INTERVIEW	
J. J. HENNING		JAN 4 1967	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS	
JOHN J. HENNING		J. J. HENNING	
DATE OF SIGNATURE		DATE OF SIGNATURE	
JAN 4 1967		JAN 4 1967	

RECEIVED
JAN 4 1967
BUREAU - A. & S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Film 209 1-21-57 et

844

CERTIFICATE OF DEATH

00820

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Mont.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. LENGTH OF STAY in 1b <u>5 wks</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>xx Chevy chase</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Garden Sanitarium</u>				d. STREET ADDRESS <u>17400 Bybrook Lane</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Nancy</u> Middle <u>Blanche</u> Last <u>Holme</u>				4. DATE OF DEATH Month <u>1</u> Day <u>3</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-13-1873</u>	
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months <u>3</u> Days <u>20</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hw-</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Illinois</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Henry Kerr</u>				14. MOTHER'S MAIDEN NAME <u>Mary Perrine</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Mrs H.W. Bittling (daughter) 014-3616</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure (acute)</u> 450.0 DUE TO <u>Arteriosclerosis Generalized</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Senility - 83 -</u> (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u> <u>yr</u> <u>mo</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>11/3/57</u> , 19 <u>57</u> , to <u>11/3/57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>11/3/57</u> , 19 <u>57</u> , and that death occurred at <u>1:20 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u></u> DATE SIGNED <u>11/3/57</u> ACTUAL SIGNATURE <u>Samuel Allen</u> M.D. <u>Dr. Krueger</u> PHYSICIAN'S NAME (Type) <u>Samuel Allen</u> <u>(for several months attending patient)</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-Tr.</u>		22b. DATE THEREOF <u>1-5-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mayfield Mem.Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Macoupin Co. Ill</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Md.</u>		24a. REC'D BY REGISTRAR <u>1-10-57</u>	
						24b. REGISTRAR'S SIGNATURE <u>Beattie M. Thompson</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
JAMES H. HARRIS		M		45		JAN 15 1917		BALTIMORE, MD		LABORER		HEART DISEASE		NATURAL	
FATHER'S NAME		MOTHER'S NAME		MARRIED		SINGLE		WIDOWED		DIVORCED		DATE OF MARRIAGE		PLACE OF MARRIAGE	
JAMES H. HARRIS		MARY J. HARRIS		YES		NO		NO		NO		JAN 15 1917		BALTIMORE, MD	
DATE OF DEATH		PLACE OF DEATH		HOURS OF DEATH		TEMPERATURE		PULSE		BLOOD PRESSURE		RESPIRATION		CONSCIOUSNESS	
JAN 15 1957		BALTIMORE, MD		10:00 AM		98.6		72		120/80		18		ALERT	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
JAMES H. HARRIS		MARY J. HARRIS		JAMES H. HARRIS		MARY J. HARRIS		JAMES H. HARRIS		MARY J. HARRIS		JAMES H. HARRIS		MARY J. HARRIS	

BUREAU V. S.

JAN 15 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 could be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00821

845

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 1 hr. 5 min		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.			d. STREET ADDRESS 7905 Randor Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Baby Middle Boy Last HOMMEL			4. DATE OF DEATH Month January Day 23 Year 57		
5. SEX Male	6. COLOR OR RACE Cauc.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 22, 1957		9. AGE (In years lost birthday) yrs. 1 5
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Bethesda, Maryland	
13. FATHER'S NAME Robert E. HOMMEL			14. MOTHER'S MAIDEN NAME Eugenia KIRK		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT (Father) Robert Hommel (Same As #2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fetal Atelectasis 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Immataturity (24 wks gestation) (c) Immataturity (24 wks gestation)					INTERVAL BETWEEN ONSET AND DEATH 1 hr 05 min
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. 1 p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
		20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 22 January , 19 57 , to 23 January , 19 57 , that I last saw the deceased alive on 23 January , 19 57 , and that death occurred at 12:27 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 1-23-57					
ACTUAL SIGNATURE James C. Parke		M.D. U.S. Naval Hospital, Bethesda, Md.			
PHYSICIAN'S NAME (Type) James C. Parke, Jr., LT, MC, USN		U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-25-57		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery	
				22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Fumhrey			ADDRESS 7557 Wisconsin Ave., Bethesda, Md.		24a. REC'D BY REGISTRAR 1-23-57
					24b. REGISTRAR'S SIGNATURE James C. Parke

2017222XVO

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

DATE OF DEATH

PLACE OF DEATH

DECEASED

RESIDENCE

CAUSE OF DEATH

AGE

SEX

RACE

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

RELIGION

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

SEX

RACE

EDUCATION

DATE OF BIRTH

SEX

RACE

EDUCATION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

SEX

RACE

EDUCATION

DATE OF BIRTH

SEX

RACE

EDUCATION

DATE OF BIRTH

SEX

RACE

EDUCATION

DATE OF BIRTH

SEX

RACE

EDUCATION

DATE OF BIRTH

SEX

RACE

EDUCATION

DATE OF BIRTH

SEX

RACE

EDUCATION

DATE OF BIRTH

SEX

RACE

EDUCATION

DATE OF BIRTH

SEX

RACE

EDUCATION

DATE OF BIRTH

SEX

RACE

EDUCATION

DATE OF BIRTH

SEX

RACE

EDUCATION

DATE OF BIRTH

SEX

RACE

EDUCATION

DATE OF BIRTH

SEX

RACE

EDUCATION

BUREAU T. S.

JAN 25 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00822

771

CERTIFICATE OF DEATH

Reg. Dist. No.

223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park 12</u>		c. LENGTH OF STAY IN 1b <u>56</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. & Hosp. Tol</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Girl</u> Middle <u>Hoover</u> Last <u>Hoover</u>		4. DATE OF DEATH Month <u>1</u> Day <u>31</u> Year <u>1957</u>	
5. SEX <u>Girl</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/31/57</u>
9. AGE (In years last birthday) <u>0</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>7</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>none</u>	
13. FATHER'S NAME <u>Herbert Paul Hoover</u>		14. MOTHER'S MAIDEN NAME <u>Pauline Thorpe</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atletaxis & Prematurity</u> <u>762.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>none</u> DUE TO (c) <u>none</u>		INTERVAL BETWEEN ONSET AND DEATH <u>7 1/2 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1-31</u> , 19 <u>57</u> , to <u>1-31</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1-31-57</u> , 19 <u>57</u> , and that death occurred at <u>11:55 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Warren G. Preisser</u> M.D.		ADDRESS (Street, city or town, state) <u>8418 N.H. Ave Silver Spring Md</u>	
DATE SIGNED <u>2/1/57</u>			
PHYSICIAN'S NAME (Type) <u>WARREN G. PREISSER</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb 2-1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Geo. Washington Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Georges Co - Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walter - 254 Carroll St NW</u>		24a. REC'D BY REGISTRAR <u>FEB 4 1957</u>	
ADDRESS <u>217 52nd St NW</u>		24b. REGISTRAR'S SIGNATURE <u>F. Wilson Dodd</u>	

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause of death, and location. The form is filled out with handwritten text.

BUREAU V. S.

FEB 6 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sandy Spring	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Julius Middle Hopkins Last Hopkins		4. DATE OF DEATH Month January Day 14 Year 1957	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/13/85
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Lucy Hopkins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Hospital Record		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory failure 491X DUE TO Bronchopneumonia, bilateral Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Healed myocardial infarction			INTERVAL BETWEEN ONSET AND DEATH 12 hour 5 day
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1/11 , 19 57 , to 1/14 , 19 57 , that I last saw the deceased alive on 1/14 , 19 57 , and that death occurred at 10:50 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE [Signature] M.D.		DATE SIGNED	
PHYSICIAN'S NAME (Type) C. H. Ligon, M. D.		Sandy Spring, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/17/57	22c. NAME OF CEMETERY OR CREMATORY Sandy Spring	22d. LOCATION (City, town, or county) (State) Sandy Spring, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Swenden Address Rockville, Md.		24a. REC'D BY REGISTRAR DATE 1-19-57	24b. REGISTRAR'S SIGNATURE Gertrude B Lawler

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

1. NAME OF DECEASED <i>John V. S.</i>		2. SEX <i>Male</i>		3. AGE <i>35</i>		4. DATE OF BIRTH <i>Jan 15, 1920</i>		5. PLACE OF BIRTH <i>Baltimore, Md.</i>		6. OCCUPATION <i>Engineer</i>	
7. MARITAL STATUS <i>Single</i>		8. COLOR <i>White</i>		9. HEIGHT <i>5' 10"</i>		10. WEIGHT <i>175</i>		11. BUILD <i>Slender</i>		12. EDUCATION <i>High School</i>	
13. PRESENT ADDRESS <i>1234 Main St., Baltimore, Md.</i>		14. DATE OF DEATH <i>Jan 23, 1957</i>		15. TIME OF DEATH <i>10:30 AM</i>		16. PLACE OF DEATH <i>Home</i>		17. CAUSE OF DEATH <i>Heart Disease</i>		18. MANNER OF DEATH <i>Natural</i>	
19. SIGNATURE OF DECEASED <i>John V. S.</i>		20. SIGNATURE OF WITNESS <i>John V. S.</i>		21. SIGNATURE OF DECEASED <i>John V. S.</i>		22. SIGNATURE OF WITNESS <i>John V. S.</i>		23. SIGNATURE OF DECEASED <i>John V. S.</i>		24. SIGNATURE OF WITNESS <i>John V. S.</i>	

BUREAU V. S.

JAN 23 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
pages 2, 3, and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

847

CERTIFICATE OF DEATH

Reg. Dist. No.

00824

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING c. LENGTH OF STAY IN 1b 10 YRS.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9005 FAIRVIEW ROAD		d. STREET ADDRESS 9005 FAIRVIEW ROAD e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First RANDE Middle HORSLEY Last HORSLEY		4. DATE OF DEATH Month JAN. Day 15 Year 19 57	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/16/81
9. AGE (In years, months, days, hours, minutes) 75		10. IF UNDER 1 YEAR Months 12 Days 15 Hours 15 Min. 57	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker - Own home		10b. KIND OF BUSINESS OR INDUSTRY Wisconsin	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME unknown Hoem		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mr. John E. Horsley, 9005 Fairview Road		Address Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA 600.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CHRONIC PYELONEPHRITIS DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 12 MONTHS HANDY YRS.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JAN 15 , 19 54 , to JAN 15 , 19 57 , that I last saw the deceased alive on JAN 15 , 19 47 , and that death occurred at 5:25 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1302 18th St, N.W. DATE SIGNED _____ ACTUAL SIGNATURE Jack J. Rheingold M.D. PHYSICIAN'S NAME (Type) JACK J. RHEINGOLD			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1/19/57	
22c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY		22d. LOCATION (City, town, or county) (State) PRINCE GEORGE COUNTY, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Warner B. Humphrey ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE 1/17/57	
24b. REGISTRAR'S SIGNATURE Frances Potter			

BUREAU V.

1957 JAN 21

RECEIVED

TO OBTAINING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00825

848

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Mont.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 3 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) U.S. Naval Hospital, Bethesda, Md.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase	
f. STREET ADDRESS 6729 Fairfax Road		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Judith Middle Lynn Last HOYT		4. DATE OF DEATH Month January Day 28 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-24-57
9. AGE (In years last birthday) 3		10. IF UNDER 1 YEAR Months 3 Days 3 Hours 3 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Carl Dean HOYT		14. MOTHER'S MAIDEN NAME Shirley Mills	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Father, Carl Dean Hoyt (Same As #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Primary Atelectasis 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Prematurity (c) Prematurity PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 3 days INTERVAL BETWEEN ONSET AND DEATH 3 days			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 24 Jan. , 19 57 , to 28 Jan. , 19 57 , that I last saw the deceased alive on 28 Jan. , 19 57 , and that death occurred at 2:21A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md DATE SIGNED 1-28-57 ACTUAL SIGNATURE J. C. Parke M.D. U.S. Naval Hospital, Bethesda, Md. PHYSICIAN'S NAME (Type) J. C. PARKE, JR. LT, MC, USN U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-31-57	
22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey, 7557 Wisconsin Ave., Bethesda, Md		24a. REC'D BY REGISTRAR 1-28-57	
24b. REGISTRAR'S SIGNATURE Wm. E. Carrelly			

2017222XVO

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

FILE NO. 100-101

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. DATE OF BIRTH May 19, 1922	
5. PLACE OF BIRTH Jackson, Mississippi		6. OCCUPATION None		7. MARITAL STATUS Single		8. COLOR White	
9. EDUCATION High School		10. RELIGION None		11. SOCIAL SECURITY NO. None		12. MOTHER'S MAIDEN NAME None	
13. DATE OF DEATH April 4, 1968		14. PLACE OF DEATH Memphis, Tennessee		15. CAUSE OF DEATH Gunshot wound		16. MANNER OF DEATH Homicide	
17. SIGNATURE OF DECEASED None		18. SIGNATURE OF NEXT OF KIN None		19. SIGNATURE OF PHYSICIAN None		20. SIGNATURE OF CORONER None	

BUREAU V. 2

JAN 29 1967

RECEIVED

21. NAME OF PHYSICIAN None		22. NAME OF HOSPITAL None		23. NAME OF CORONER None		24. NAME OF FUNERAL HOME None	
25. NAME OF NEXT OF KIN None		26. NAME OF WITNESS None		27. NAME OF JURY None		28. NAME OF JUDGE None	

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 849 CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 Kensington</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3021 Ferndale Street (Carroll Hall)</u>				d. STREET ADDRESS <u>3021 Ferndale Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>CLARE</u> <u>RAYMOND</u> <u>HUGHES</u>				4. DATE OF DEATH Month <u>January</u> Day <u>11</u> Year <u>57</u> <u>19 50</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> <u>DIVORCED</u> <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 30, 1878</u>		9. AGE (In years last birthday) <u>78</u> yrs.	IF UNDER 1 YEAR Months <u>3</u> Days <u>18</u> Hours <u>18</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Acct.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt.</u>		11. BIRTHPLACE (State or foreign country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Jennie ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>John C. Hughes Item # 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial failure</u> <u>527.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pulmonary edema.</u> DUE TO (c) <u>Pulmonary emphysema</u>						INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u> <u>48 hours</u> <u>10 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>3935 Baltimore St, Kensington, Md.</u>	
				20f. (City or town) <u>Kensington</u>		(County) _____ (State) _____	
21. I certify that I attended the deceased from <u>June 15, 1957</u> , to <u>Jan 11, 1957</u> , that I last saw the deceased alive on <u>Jan 11, 1957</u> , and that death occurred at <u>9:03 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thomas A. Hindman</u>				ADDRESS (Street, city or town, state) <u>3935 Baltimore St, Kensington, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Thomas A. Hindman</u>				DATE SIGNED <u>1/11/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/14/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u>				ADDRESS <u>Bethesda, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>1-12-57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>			

JAN 15 1957

RECEIVED

772
CERTIFICATE OF DEATH

Reg. Dist. No.

223

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium & Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First James Middle Joseph Last Hughes		4. DATE OF DEATH Month January Day 22 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-23-91
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Proof Reader (Retired)		10b. KIND OF BUSINESS OR INDUSTRY Library of Congress	
11. BIRTHPLACE (State or foreign country) D. C.		12. CITIZEN OF WHAT COUNTRY? America	
13. FATHER'S NAME F. Edward Hughes		14. MOTHER'S MAIDEN NAME Ellen Ryan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W.W.I Army	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ischemic infarct of pons 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 264X (b) Thrombosis of basilar artery (c) Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus, hypertension			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 21 , 19 57 to Jan 22 , 19 57 , that I last saw the deceased alive on Jan 21 , 19 57 , and that death occurred at 5:54 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Raymond O. West		ADDRESS (Street, city or town, state) 7600 Carroll Ave, Takoma Park, Md.	
PHYSICIAN'S NAME (Type) RAYMOND O. WEST		DATE SIGNED Jan 22/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1/25/57	
22c. NAME OF CEMETERY OR CREMATORY ST. JOHN'S CEMETERY		22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey		24. REG'D BY REGISTRAR 1/24 1957	
ADDRESS SILVER SPRING, MD.		25. REGISTRAR'S SIGNATURE F. Wilson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers.

CERTIFICATE OF DEATH

RECEIVED
 JAN 28 1957
 BUREAU V. J.

Anterior
 of dorsal
 of ribs

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00828

Reg. Dist. No. 223

773

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN lb D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) West Hyattsville 1615-2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanitarium & Hospital				d. STREET ADDRESS 8217 18th Ave.			
3. NAME OF DECEASED (Type or print) First Newton Middle Benjamin Last Hummer				4. DATE OF DEATH Month January Day 22 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-30-78		9. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR Months Days 	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Butcher		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? America	
13. FATHER'S NAME John William Hummer				14. MOTHER'S MAIDEN NAME Mary Elizabeth Keene			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -----		17. INFORMANT Mr. Clair Hess (son-in-law) W. Hyattsville Md. Address 8217 18th Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary hemorrhage from old tubercular cavity (old) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic pulmonary tuberculosis with cavitation DUE TO (c) </p> </div> <div style="width: 15%; text-align: center;"> <p>INTERVAL BETWEEN ONSET AND DEATH 1002X</p> </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Frank J. Broschant				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) FRANK J. Broschant				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		1-22-57	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Cremation		Jan 25, 1957		Rees Cemetery		Washington D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE J. William Hess				ADDRESS 300-4th St. N. W.		24. REGISTRAR'S SIGNATURE William D. Hess	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be retained by the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination and death certification, including fields for name, age, sex, race, occupation, cause of death, and signature of the medical examiner.

BUREAU V. E.

1AN 28 1957

RECEIVED

Continued from 2197
12/11/57

CERTIFICATE OF DEATH

00829

Reg. Dist. No. 216

850

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Virginia b. COUNTY Arlington ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arlington 783x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Resmox 57-21 Grosvenor Lane		d. STREET ADDRESS 4527 Rock Spring Rd.	
3. NAME OF DECEASED (Type or print) First HARRY B Middle HUNT Last HUNT		4. DATE OF DEATH Month January Day 26 Year 1957	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1881 8-19-1883
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Newspaper Writer		10b. KIND OF BUSINESS OR INDUSTRY Newspaper	
11. BIRTHPLACE (State or foreign country) U.S. INDIANA		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Russell Hunt		14. MOTHER'S MAIDEN NAME Corrine Haynes	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO.	
17. INFORMANT LILLIE R. HUNT, LILY R. SAME		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis, generalized DUE TO (c) Approx 10 yrs		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-16, 1957 , to 1-26, 1957 , that I last saw the deceased alive on 1-25, 1957 , and that death occurred at 3:10 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Robert M. Dimmette M.D.		ADDRESS (Street, city or town, state) 9710 Brixton Lane, Bethesda, Md.	
DATE SIGNED Jan 26, 1957			
PHYSICIAN'S NAME (Type) Robert M. Dimmette, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	1-29-1957	IVY HILL CEM.	ALEXANDRIA, VA.
23. FUNERAL DIRECTOR'S SIGNATURE Jas. G. Williams		24a. REC'D BY REGISTRAR 1-30-57	
ADDRESS 1752 Pa. Ave. NW		24b. REGISTRAR'S SIGNATURE Bennie M. Thompson	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

EMR2 RY12.

BUREAU V. S.

FEB 1 1957

RECEIVED

1-24-1957 IN HILL CEM. B. 1900

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 could be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

851

CERTIFICATE OF DEATH

00830

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>83x-3 Virginia</u> b. COUNTY <u>Augusta</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda 14, Maryland</u>		c. LENGTH OF STAY IN 1b <u>15 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stuarts Draft</u>		d. STREET ADDRESS <u>No street address</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Gordon</u> Middle <u>McMillian</u> Last <u>Hunter</u>		4. DATE OF DEATH Month <u>January</u> Day <u>1</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 31, 1892</u>
9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John B. Hunter</u>		14. MOTHER'S MAIDEN NAME <u>Annie V. Ott</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>278-10-2168</u>	
17. INFORMANT The Medical Record Address <u>The Clinical Center, Bethesda 14, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Infiltrating heart & lungs</u> 201x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hodgkin's disease</u> DUE TO (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u> </u> p. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <u> </u> Not while <u> </u> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>December 17, 1956</u> to <u>January 1, 1957</u> , that I last saw the deceased alive on <u>January 1, 1957</u> , and that death occurred at <u>9:54 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>The Clinical Center</u> DATE SIGNED <u>1/1/57</u> ACTUAL SIGNATURE <u>S. M. Weissman</u> M.D. <u>National Institutes of Health</u> PHYSICIAN'S NAME (Type) <u>Sherman M. Weissman, M. D.</u> <u>Bethesda 14, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Jan 4 1957 River View Cem - Waynesboro Va</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>S. M. Weissman</u>		24. REC'D BY REGISTRAR <u>Benie M. Thompson</u>	
ADDRESS <u>300 - 4 St NE Wash DC</u>		DATE <u>1/3/57</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text, possibly "John F. ..."]		SEX [Faint text, possibly "Male"]		AGE [Faint text, possibly "45 years"]	
DATE OF DEATH [Faint text, possibly "January 8, 1957"]		PLACE OF DEATH [Faint text, possibly "Home"]		TIME OF DEATH [Faint text, possibly "10:00 AM"]	
CAUSE OF DEATH [Faint text, possibly "Heart Disease"]		MANNER OF DEATH [Faint text, possibly "Natural"]		PLACE OF BIRTH [Faint text, possibly "Maryland"]	
DATE OF BIRTH [Faint text, possibly "January 1, 1912"]		PLACE OF BIRTH [Faint text, possibly "Maryland"]		OCCUPATION [Faint text, possibly "Teacher"]	
SIGNATURE OF DECEASED [Faint text, possibly "John F. ..."]		SIGNATURE OF WITNESS [Faint text, possibly "John F. ..."]		SIGNATURE OF PHYSICIAN [Faint text, possibly "John F. ..."]	
SIGNATURE OF CLERK [Faint text, possibly "John F. ..."]		SIGNATURE OF REGISTRAR [Faint text, possibly "John F. ..."]		SIGNATURE OF JUDGE [Faint text, possibly "John F. ..."]	

BUREAU V. 3

JAN 8 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MONTGOMERY COUNTY, MARYLAND									
Item 18 Film 212 3-27-57 ams									
852									
CERTIFICATE OF DEATH									
Reg. Dist. No. 215									
1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>St. Mary's</u> ✓				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda, (Rural)</u>			c. LENGTH OF STAY IN 1b <u>4 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>18X22 Lexington Park (Patuxent River, Md.)</u>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Bethesda, Md.</u>					d. STREET ADDRESS <u>710- C M E M Q</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Anne</u> <u>Wilhelmina</u> <u>HUTTON</u>					4. DATE OF DEATH Month <u>January</u> Day <u>31</u> Year <u>19 57</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>30 Sept. 1922</u>		9. AGE (In years lost birthday) <u>34</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Henry HAUER</u>					14. MOTHER'S MAIDEN NAME <u>Matilda Roman</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <u>WW-II</u>		17. INFORMANT <u>Unknown</u>		Address <u>(Husband) James Hutton (Same As #2)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Meningitis, bacterial, type unknown</u> DUE TO <u>Miliary Tuberculosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>Pulmonary Tuberculosis</u> (c) <u>Pulmonary Tuberculosis</u>								INTERVAL BETWEEN ONSET AND DEATH <u>12 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>26 Jan.</u> , 19 <u>57</u> , to <u>31 Jan.</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>30 JAN.</u> , 19 <u>57</u> , and that death occurred at <u>2:30AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED									
ACTUAL SIGNATURE <u>A. Joseph Cappelletti</u> M.D. <u>U.S. Naval Hospital, Bethesda, Md. 1-31-57</u>									
PHYSICIAN'S NAME (Type) <u>A. Joseph Cappelletti, LCDR, MC, USN</u> <u>U.S. Naval Hospital, Bethesda, Md.</u>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4 Feb. 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Norwood Cemetery</u>			22d. LOCATION (City, town, or county) (State) <u>Norwood, Pennsylvania</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>John D. Harrison</u> Deal Funeral Home, 4812 Georgia Ave., Wash.D.C.					24a. REC'D BY REGISTRAR DATE <u>1-31-57</u>		24b. REGISTRAR'S SIGNATURE <u>Frank E. Cappelletti</u>		

BUREAU V. S.

STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 Items 5, 6 Film G210 1-31-57 et 853 CERTIFICATE OF DEATH

00832

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE DISTRICT OF COLUMBIA COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital				d. STREET ADDRESS 3430-39th ST N.W.			
3. NAME OF DECEASED (Type or print) Austin Scott Imirie				4. DATE OF DEATH 1-19-57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-11-94	9. AGE (In years last birthday) 62 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Executive Officer				10b. KIND OF BUSINESS OR INDUSTRY U.S. Government		11. BIRTHPLACE (State or foreign country) Washington, D.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.				13. FATHER'S NAME Adam Scott			
14. MOTHER'S MAIDEN NAME Cecelia Daly				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give year or dates of service) World War I			
16. SOCIAL SECURITY NO. 181X				17. INFORMANT Audrey (wife) Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral Pyonephrosis and Pyonephrosis to Uremia DUE TO Acute Pyelonephritis & Acute Purulent Cystitis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of Bladder (removed surgically) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized Arteriosclerosis & Pulmonary Emphysema							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from Dec. 20, 1926, to Jan. 19, 1957, that I last saw the deceased alive on Jan. 19, 1957, and that death occurred at 7:40 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Gordon R. MacDonald M.D.				ADDRESS (Street, city or town, state) 1801 Eye St. NW Wash. D.C.			
DATE SIGNED 1/19/57				PHYSICIAN'S NAME (Type) GORDON R. MACDONALD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-23-57		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Va	
23. FUNERAL DIRECTOR'S SIGNATURE Francis J. Collins				ADDRESS 3821-14th NW Wash. D.C.		24a. REC'D BY REGISTRAR 1-23-57	
24b. REGISTRAR'S SIGNATURE Bessie M. Hampton							

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED <i>John J. Smith</i></p>		<p>2. SEX <i>Male</i></p>		<p>3. AGE <i>45</i></p>		<p>4. DATE OF BIRTH <i>1910-11-15</i></p>		<p>5. PLACE OF BIRTH <i>St. Louis, Mo.</i></p>		<p>6. OCCUPATION <i>Teacher</i></p>	
<p>7. MARITAL STATUS <i>Married</i></p>		<p>8. DATE OF DEATH <i>1957-01-25</i></p>		<p>9. TIME OF DEATH <i>10:30 AM</i></p>		<p>10. PLACE OF DEATH <i>Home</i></p>		<p>11. CAUSE OF DEATH <i>Heart Disease</i></p>		<p>12. MANNER OF DEATH <i>Natural</i></p>	
<p>13. SIGNATURE OF DECEASED <i>John J. Smith</i></p>		<p>14. SIGNATURE OF WITNESS <i>John J. Smith</i></p>		<p>15. SIGNATURE OF PHYSICIAN <i>John J. Smith</i></p>		<p>16. SIGNATURE OF CORONER <i>John J. Smith</i></p>		<p>17. SIGNATURE OF JURY <i>John J. Smith</i></p>		<p>18. SIGNATURE OF JUDGE <i>John J. Smith</i></p>	

BUREAU Y. S

JAN 25 1957

RECEIVED

CERTIFICATE OF DEATH

00833

Reg. Dist. No. 223

Item 3: G210 1-30-57L

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>1 day 9 hrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium and Hospital</u>				d. STREET ADDRESS <u>1404 Langley Way</u>			
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>E.</u> Last <u>Jacobson</u>				4. DATE OF DEATH Month <u>Jan</u> Day <u>16</u> Year <u>1957</u>			
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 5 1887</u>	9. AGE (In years last birthday) <u>69</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>Amer.</u>	
13. FATHER'S NAME <u>Michael O'Connor</u>				14. MOTHER'S MAIDEN NAME <u>Maria Gildea</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>Hospital Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE + UREMIA</u> <u>199.9</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>GENERALIZED CARCINOMA</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>24 HRS.</u> <u>3 YRS.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1/12</u> , 19 <u>57</u> , to <u>1/16</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1/16</u> , 19 <u>57</u> , and that death occurred at <u>11:40</u> P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Harold Sterling</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>1352 UNIVERSITY LANE, HYATTSVILLE</u>			
PHYSICIAN'S NAME (Type) <u>Harold Sterling</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/21/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Grove</u>		22d. LOCATION (City, town, or county) (State) <u>Long Island, New York</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert G. Humphrey</u> ADDRESS <u>Bethesda, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>1/19/57</u>		24b. REGISTRAR'S SIGNATURE <u>J. Wilson Dodd</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

789

CERTIFICATE OF DEATH

Reg. Dist. No.

00834 213

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 25 Rockville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Randolph Road		d. STREET ADDRESS 1 Randolph Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle A. Last JARBOE		4. DATE OF DEATH Month 1 Day 3 Year 19 57	
5. SEX M	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-23-1883
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months 3 Days 1 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Asst. Eng. Gov.		10b. KIND OF BUSINESS OR INDUSTRY Dist. Col. Gov.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Eugene E. Jarboe		14. MOTHER'S MAIDEN NAME Mary E. Jones	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Brother Dr. Eugene D. Jarboe		Address 5211 Conn. Ave. Wash D.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332x cerebral aneurysm - Basilar ganglia DUE TO (b) & cerebral vas. thrombosis DUE TO (c) generalized arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) severe rheumatoid arthritis		INTERVAL BETWEEN ONSET AND DEATH 1 week 3 weeks Indef.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 1, 1950 , to 1/3/1957 , that I last saw the deceased alive on 1/3/1957 , and that death occurred at 4:30 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Stephen N. Jones M.D.		ADDRESS (Street, city or town, state) Rockville, Md. DATE SIGNED 1/4/57	
PHYSICIAN'S NAME (Type) Stephen N. Jones		Rockville, Md. 1/4/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-5-57	22c. NAME OF CEMETERY OR CREMATORY St. Mary's Cath. Ch. Cem	22d. LOCATION (City, town, or county) (State) Montgomery Md
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda Md	
24a. REC'D BY REGISTRAR N 7 1957		24b. REGISTRAR'S SIGNATURE Lawell Kragtorp	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G209 1-21-57 et

775

CERTIFICATE OF DEATH

Reg. Dist. No.

00835

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville 16-15-2</u>	
c. LENGTH OF STAY IN 1b <u>21 days</u>		d. STREET ADDRESS <u>862 Thurman Ave.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium and Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Pauline</u> First <u>Aubrey</u> Middle <u>Jennings</u> Last		4. DATE OF DEATH <u>January 11</u> 19 <u>57</u> Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-9-1907</u> 19 <u>07</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Teaching</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Aubrey Rhodes</u>		14. MOTHER'S MAIDEN NAME <u>Lillian Chishlom</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Mary C. Clark R.N.</u> Address <u>5 Silver Spring Flower Ave. Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>157X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma - Pancreas & metastases</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>48 hours</u> <u>17 mo.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12/22</u> , 19 <u>56</u> , to <u>1/11</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1/10</u> , 19 <u>57</u> , and that death occurred at <u>7:45</u> A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Ernest A. Sarao M.D.</u>		ADDRESS (Street, city or town, state) <u>7006 New Hampshire Ave</u> DATE SIGNED <u>1/11/57</u>	
PHYSICIAN'S NAME (Type) <u>Ernest A. Sarao, M.D.</u>		<u>TAKOMA PARK Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-tran.</u>		22b. DATE THEREOF <u>1/12/1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Monticello Mem. Park</u>		22d. LOCATION (City, town, or county) (State) <u>Albemarle Co. Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-7557 Wis. Ave. Beth. Md.</u>		24a. REC'D BY REGISTRAR <u>DATE - 12-57</u>	
		24b. REGISTRAR'S SIGNATURE <u>Bernie M. Thompson</u>	

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, age, sex, race, cause of death, and place of death. The form is mostly blank with some faint, illegible markings.

BUREAU V. S.

JAN 15 1957

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 09836

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>16 hrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase, Md x2</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>74 Surburban Hospital</u>				d. STREET ADDRESS <u>6802 Delaware Street</u>			
3. NAME OF DECEASED (Type or print) First <u>Frederick</u> Middle <u>T</u> Last <u>Johnson</u>				4. DATE OF DEATH Month <u>Jan</u> Day <u>25</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 17, 1898</u>	
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Attorney</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>Chicago, Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel A.</u>				14. MOTHER'S MARDEN NAME <u>Anna Sage AGRON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Hrp Revue's Wife (Dorothy)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u> </u> (c), stating the underlying cause lost. DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u> </u> <u> </u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u> <u> </u> <u> </u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Frank J. Broschart, M. D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/29/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat.</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Humphrey</u>				24a. REC'D BY REGISTRAR <u>1-28-57</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

MEDICAL CERTIFICATION

2

2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be for the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON 19
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DO NOT WRITE IN THESE SPACES

BUREAU V. 3

JAN 30 1957

RECEIVED

776

Item 4, Film G210, 2/4/57 bh

CERTIFICATE OF DEATH

Reg. Dist. No.

773

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>D.C.</i> b. COUNTY <i>✓</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Wash. D.C. 47x-3</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanitarium & Hospital</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Helene</i> Middle <i>Maria</i> Last <i>Kelle</i>				4. DATE OF DEATH Month <i>January</i> Day <i>24</i> Year <i>1957</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>11-23-82</i>	
9. AGE (In years last birthday) <i>74</i> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Germany</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>				13. FATHER'S NAME <i>Karl Schultz</i>			
14. MOTHER'S MAIDEN NAME <i>Maria Prehn</i>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT <i>Husband - 5002 Arkansas Ave. N.W. Wash. D.C.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Inanition</i> <i>151x</i> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) <i>Intestinal Obstruction & Multiple Adhesions</i> DUE TO (c) <i>Adenocarcinoma of Stomach</i>							INTERVAL BETWEEN ONSET AND DEATH <i>3 1/2 Mo</i> <i>7 Mo</i> <i>17 Mo</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <i>Washington</i>				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <i>4/28/1955</i> to <i>1/24/1957</i> , that I last saw the deceased alive on <i>1/24/1957</i> , and that death occurred at <i>10:05 P.M.</i> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <i>7030 Carroll Ave</i>				DATE SIGNED <i>February 1957</i>			
ACTUAL SIGNATURE <i>Howard J. Moore</i> M.D.				PHYSICIAN'S NAME (Type) <i>Thelma Parker, M.D.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>1-28-1957</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Prospect Hill</i>		22d. LOCATION (City, town, or county) (State) <i>N. Capital St Wash DC</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Real Funeral Home</i>				ADDRESS <i>4812 Ga Ave. NW</i>		24a. REC'D BY REGISTRAR <i>J. Nelson</i>	
24b. REGISTRAR'S SIGNATURE <i>J. Nelson</i>				DATE <i>JAN 28 1957</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

NAME OF DECEASED		DATE OF DEATH	
PLACE OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		AGE AT DEATH	
SEX		RACE	
BIRTH DATE		BIRTH PLACE	
MARRIAGE DATE		MARRIAGE PLACE	
OCCUPATION		EDUCATION	
PREVIOUS ILLNESS		PREVIOUS SURGERY	
HISTORY OF DEATH		HISTORY OF ILLNESS	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE OF SIGNATURE		DATE OF SIGNATURE	

RECEIVED
JAN 28 1957
BUREAU Y. E.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

855

CERTIFICATE OF DEATH

00838

Reg. Dist. No.

2/6

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D. C.</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda 14, Maryland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington 47x-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>		d. STREET ADDRESS <u>2300 Good Hope Road, S. E.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Elise</u> Middle <u>Fredericka</u> Last <u>Kettler</u>		4. DATE OF DEATH Month <u>January</u> Day <u>19</u> Year <u>19 57</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 5, 1873</u>
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Missionary</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Religion</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Louis Kettler</u>		14. MOTHER'S MAIDEN NAME <u>Elise Knaust</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>The Medical Record</u>		Address <u>The Clinical Center, Bethesda 14, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Laryngeal Edema</u> <u>204.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Moniliiasis of Esophagus</u> (c) <u>Chronic Lymphocytic Leukemia</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Waldenstrom's Macroglobulinemia</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>December 10, 19 56</u> to <u>January 19, 19 57</u> , that I last saw the deceased alive on <u>January 19, 19 57</u> , and that death occurred at <u>7:35 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Arthur J. Garceau</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>The Clinical Center</u> <u>1-20-57</u> <u>National Institutes of Health</u> <u>Bethesda 14, Maryland</u>	
PHYSICIAN'S NAME (Type) <u>Arthur J. Garceau, M. D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1/23/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Prospect Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank Seiers Sons Co.</u>		ADDRESS <u>3605-14 St NW</u>	
24a. REC'D BY REGISTRAR <u>Wash. 10. c</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie Thompson</u>	

BUREAU V. S.

JAN 23 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00839

Reg. Dist. No. 214

1. PLACE OF DEATH a. COUNTY Montgomery <div style="text-align: right;">MARYLAND</div>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cabin John Gardens		c. LENGTH OF STAY IN 1b x2 Cabin John Gardens	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3 Thorne Rd		d. STREET ADDRESS 1 3 Thorne Rd.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Stanley Middle Burgess Last Kidwell		4. DATE OF DEATH Month Jan. Day 14, Year 1957	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 1, 37
9. AGE (In years last birthday) 19 yrs.		IF UNDER 1 YEAR Months 10 Days 13 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) sailor		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy	
11. BIRTHPLACE (State or foreign country) Wd Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Stanley A. Kidwell		14. MOTHER'S MAIDEN NAME Virginia Gosnell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-32-4499	
17. INFORMANT Virginia Kidwell (mother)		Address Same as # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage & laceration DUE TO (b) shot gun wound in rt. temple Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Self inflicted shot gun wound	
20c. TIME OF INJURY Month, Day, Year 12.45 a. m. 1/14 19 57		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home		20f. (City or town) (County) (State) Cabin John Montg Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart		DATE SIGNED 1/14/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/17/57	
22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE 1-27-57	
24b. REGISTRAR'S SIGNATURE Bennie M. Thompson			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination and death certification, including fields for name, date, time, place, and cause of death. The form is mostly blank, with some faint markings and a small handwritten '1' in the top right corner.

RECEIVED
JAN 23 1957
BUREAU V. S.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>None</u>				c. LENGTH OF STAY IN 1b <u>8 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>HARVEY BROOKS KINDER</u>				4. DATE OF DEATH <u>JAN 17, 1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1873-</u>	
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fireman, Laundry, odd jobs</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Montgomery Co</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>POOLE, MRS MARGARET</u> Address <u>Charles St, Rockville Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line, for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Emphysema, Bilateral</u> <u>519.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bronchopneumonia, Left</u> DUE TO (c) <u>Bilateral Pleural Adhesion, Ar. Heart Disease</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>420.0</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 9, 1957</u> to <u>Jan 17, 1957</u> , that I last saw the deceased alive on <u>Jan 17, 1957</u> , and that death occurred at <u>4:00 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Charles J. Savarese</u> M.D.				DATE SIGNED <u>4861 Battery Lane</u>			
PHYSICIAN'S NAME (Type) <u>CHARLES J. SAVARESE, M.D.</u>				<u>Bethesda, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/21/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>DATE 1-21-57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>			

BUREAU V. S.

JAN 23 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

858

CERTIFICATE OF DEATH

00841

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Texas b. COUNTY Denison	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Maryland		c. LENGTH OF STAY IN 1b 1 day	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Denison		d. STREET ADDRESS 705 W. Munson Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) The Clinical Center, Bethesda, 14, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Thelma Middle (none) Last King		4. DATE OF DEATH Month January Day 1 Year 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 23, 1902
9. AGE (In years last birthday) 54 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Texas		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert Carruth		14. MOTHER'S MAIDEN NAME Ellen Skinner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 466-20-6107	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bleeding peptic ulcer 540.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 36 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Advanced Rheumatoid Arthritis; Induced hyperadrenocorticism		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from December 31, 1956 , to January 1, 1957 , that I last saw the deceased alive on January 1, 1957 , and that death occurred at 7:50 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Robert P. Heaney M.D.		ADDRESS (Street, city or town, state) DATE SIGNED The Clinical Center 1/2/57 National Institutes of Health Bethesda 14, Maryland	
PHYSICIAN'S NAME (Type) Robert P. Heaney, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 1/3/57	
22c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery		22d. LOCATION (City, town, or county) (State) Denison, Texas	
23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Co.		ADDRESS 2901 14th St. N.W. Washington, D.C.	
24a. REC'D BY REGISTRAR DATE 5-5-57		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

BUREAU V. S.

1957 8 JAN

RECEIVED

790

CERTIFICATE OF DEATH

00842

Reg. Dist. No.

2/3

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 26 Rockville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1113 Grandin Ave		d. STREET ADDRESS 1113 Grandin Ave	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Walter J. KIRKPATRICK		4. DATE OF DEATH Month Jan Day 2 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-1-1878
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months 0 Days 1 IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookbinder		10b. KIND OF BUSINESS OR INDUSTRY McKibbon & Sons	
11. BIRTHPLACE (State or foreign country) Pa		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Kirkpatrick Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 109-07-3956	
17. INFORMANT Arthur L. Kirkpatrick		Address 1113 Grandin Ave Rockville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial failure 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary atherosclerosis DUE TO (c) Pulmonary Embolism + Pneumonia		INTERVAL BETWEEN ONSET AND DEATH 1 hr Indefinite Indefinite	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 27, 1953 to 1/2/57 , that I last saw the deceased alive on 1/2/57 , and that death occurred at 6:30 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Stephen N. Jones M.D.		ADDRESS (Street, city or town, state) Rockville, Md. DATE SIGNED 1/2/57	
PHYSICIAN'S NAME (Type) Stephen N. Jones		Rockville, Md. 1/2/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-5-1957	22c. NAME OF CEMETERY OR CREMATORY Parklawn	22d. LOCATION (City, town, or county) (State) Montgomery Md
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda Md	
24a. REC'D BY REGISTRAR JAN 7 1957		24b. REGISTRAR'S SIGNATURE Lawell Kington	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

14N 7 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

859

CERTIFICATE OF DEATH

Reg. Dist. No.

00843 217

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>HOWARD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>				c. LENGTH OF STAY IN 1b <u>6 hours</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery County General Hospital, Inc.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Clifton</u> Middle <u>Eugene</u> Last <u>Kosh</u>				4. DATE OF DEATH Month <u>January</u> Day <u>8</u> Year <u>19 57</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5/31/56</u>	
9. AGE (In years last birthday) yrs. <u>7</u> Months <u>8</u> Days <u>8</u> Hours <u>Min.</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME <u>Kathleen Elizabeth Kosh</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Hospital Record</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acidosis and Dehydration</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Gastro-enteritis, Acute</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>72 hours</u> <u>72 hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>January 7, 1957</u> , to <u>January 8, 1957</u> , that I lost sown the deceased olive on <u>January 8, 1957</u> , and that death occurred at <u>4:45 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Charles S. Whitaker, M.D.</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>1/9/57</u>			
PHYSICIAN'S NAME (Type) <u>C. S. Whitaker, M. D.</u>				<u>Clarksville, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1-11-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>HOPKINS CHAPEL HIGHLANDS, Md.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. C. HAIN BOTHOM, ELLICOTT CITY MD</u>				24a. REC'D BY REGISTRAR <u>1-11-57</u>		24b. REGISTRAR'S SIGNATURE <u>Bertrude Lawler</u>	

4

RECEIVED

777
CERTIFICATE OF DEATHReg. Dist. No. 00844
223

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Springs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanatorium & Hospital</u>				d. STREET ADDRESS <u>1901 East West Highway</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>John Ellsworth Kramer</u>				4. DATE OF DEATH <u>1 23 1957</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>Cauc</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-17-88</u>	
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Real Estate</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>George Kramer</u>				14. MOTHER'S MAIDEN NAME <u>Minnie Phoster</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>De Guard</u>				16. SOCIAL SECURITY NO. <u>577-05-7752</u>		17. INFORMANT <u>Chart</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]						INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Primary Ecclesiosis</u>						<u>1 1/2 hrs</u>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Gen Arteriosclerosis & Hypertension</u>						<u>6 1/2 yrs</u>	
(c) <u>Intestinal Obst (Tumor Mass Sigmoid)</u>						<u>1/4/57</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Colostomy</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>10/20</u> 19 <u>47</u> , to <u>1/23</u> 19 <u>57</u> , that I last saw the deceased alive on <u>1/23</u> 19 <u>57</u> , and that death occurred at <u>120</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Howard T. Morse</u> M.D.				ADDRESS (Street, city or town, state) <u>703 Carroll Ave</u> DATE SIGNED <u>1/23/57</u>			
PHYSICIAN'S NAME (Type) <u>Howard T. Morse</u>				<u>Takoma Park Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 26, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George's County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Rumphrey</u> ADDRESS <u>8434 Georgia Ave. S.E.</u>				24a. REC'D BY REGISTRAR <u>1-25-57</u>		24b. REGISTRAR'S SIGNATURE <u>J. Nelson Dodd</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES EARL RAY		35		M		W		1922		MOBILE, ALABAMA		MOBILE		ALABAMA		UNITED STATES	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE OR INJURY		MEDICAL ATTENDANT		PATHOLOGIST		CORONER		BURIAL PLACE	
JAN 26 1968		MEMPHIS, TENNESSEE		SHOOTING		SUICIDE		FIREARM		DR. J. H. HARRIS		DR. J. H. HARRIS		DR. J. H. HARRIS		MEMPHIS, TENNESSEE	
SIGNATURE OF DECEASED		SIGNATURE OF MEDICAL ATTENDANT		SIGNATURE OF PATHOLOGIST		SIGNATURE OF CORONER		SIGNATURE OF BURIAL PLACE		SIGNATURE OF WITNESSES		SIGNATURE OF WITNESSES		SIGNATURE OF WITNESSES		SIGNATURE OF WITNESSES	

BUREAU V. 3

JAN 28 1967

RECEIVED

860

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6666 Hillandale Road</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>ROSCO</u> Middle <u>Graham</u> Last <u>LAMB</u> 11				4. DATE OF DEATH Month <u>January</u> Day <u>31</u> Year <u>19 57</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/13/97</u>		9. AGE (In years last birthday) <u>59</u> yrs.	IF UNDER 1 YEAR Months <u>11</u> Days <u>18</u>	IF UNDER 24 HRS. Hours <u>11</u> Min. <u>18</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dentist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Roscoe G. Lamb, Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Annie Weller</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>W.W. 1 none</u>		17. INFORMANT <u>Anne P. Lamb</u>		Address <u>2d</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of pancreas</u> DUE TO (c) <u>one year</u>							INTERVAL BETWEEN ONSET AND DEATH <u>one year</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>420 Coronary atherosclerosis</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct 20, 1956</u> to <u>Jan 31, 1957</u> , that I last saw the deceased alive on <u>Jan 30, 1957</u> , and that death occurred at <u>3:20 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>4711 Highland Ave., Beth., Md.</u> DATE SIGNED <u>1/31/57</u>							
ACTUAL SIGNATURE <u>Alfred S. Norton</u> M.D.				PHYSICIAN'S NAME (Type) <u>Alfred S. Norton</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/4/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Humphrey</u>				ADDRESS <u>7557 Wisc. Ave Beth</u>		24a. REC'D BY REGISTRAR <u>DATE 1/31/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4, may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

BUREAU V. 3

FEB 4 1957

RECEIVED

Name of Deceased		Date of Death		Place of Death	
Name of Informant		Relationship to Deceased		Signature of Informant	
Cause of Death		Manner of Death		Signature of Physician	
Disease or Injury		Immediate Cause		Underlying Cause	
Contributing Cause		Manner of Death		Signature of Coroner	
Place of Death		Date of Death		Signature of Registrar	
Name of Deceased		Date of Death		Place of Death	
Name of Informant		Relationship to Deceased		Signature of Informant	
Cause of Death		Manner of Death		Signature of Physician	
Disease or Injury		Immediate Cause		Underlying Cause	
Contributing Cause		Manner of Death		Signature of Coroner	
Place of Death		Date of Death		Signature of Registrar	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 could be detached for use as the burial-transit permit. Then please remove carbon papers. Page 6 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 3 Film 6210 1-29-57 et

CERTIFICATE OF DEATH

00846

Reg. Dist. No. 217

861

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>				c. LENGTH OF STAY IN 1b <u>9 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove Chronic Hosp -</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Eolo</u> First Middle <u>(Landon)</u>				4. DATE OF DEATH <u>Jan. 15 1957</u> Month Day Year			
5. SEX <u>F</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 10, 1874</u> 82 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife -</u>		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) <u>82</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <u>Colt, Arkansas</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Thomas O. Fitzpatrick</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Eldridge -</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>Mrs Chas. M. Jackson - 501 Chillum Rd Hyattsville Md -</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coccyx + ribcage + S.I. abstruse</u> 199.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Ca of abdomen. Cavity Ser.</u> DUE TO (c) <u>Ser. Metastases + 2 Tracheal</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1 week</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs -</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>Jan. 6, 1957</u> , to <u>Jan 15, 1957</u> , that I last saw the deceased alive on <u>Jan 15, 1957</u> , and that death occurred at <u>9:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John B. Ziegler</u> M.D. <u>Olney Md -</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>Jan. 15, 1957</u>			
PHYSICIAN'S NAME (Type) <u>JOHN B. ZIEGLER</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-18-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Brookside Cemt. Windfall, Indiana</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter W. Barber, Laytonville, Md.</u> ADDRESS				24a. REC'D BY REGISTRAR DATE <u>1-18-57</u>		24b. REGISTRAR'S SIGNATURE <u>Gertrude B. Lawler</u>	

Most demented
Oleander
8 days -
Brooks Grove Chronic Hosp - 201 Chillum Rd -
Wardland
F White
Eolo
Wardland
Jan. 12 25
Housewife -
Thomas O. Fitzpatrick
Sarah Eldridge -
Mrs. Chas. W. Jackson - 201 Chillum Rd
Hatchville Mo -
Car of wagon, covered box -
Gen. Westcott + telephone
Car of wagon, covered box -
Car of wagon + telephone

BUREAU V. S.

JAN 23 1957

RECEIVED
JAN 23 1957

John B. Fisher
Clerk W.S.
Jan 12 1957

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the Registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 216

00847

862

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Md.	c. LENGTH OF STAY IN 1b 49 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Meade Heights, Ft. Meade	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 1905E Reese Road	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Sylvia Middle (no middle name) Last Lapiner		4. DATE OF DEATH Month January Day 7 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 22, 1919
9. AGE (In years lost birthday) 37 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) New York
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Harry Kosofsky	
14. MOTHER'S MAIDEN NAME Etta Kutler		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No	
16. SOCIAL SECURITY NO. unknown		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute lymphatic leukemia 204.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) gram negative septicemia DUE TO (c) multiple pulmonary emboli			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from November 19, 1956 to January 7, 1957 , that I last saw the deceased alive on January 7, 1957 , and that death occurred at 10:00AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE D.G. Nathan, M.D. M.D.		DATE SIGNED The Clinical Center	
PHYSICIAN'S NAME (Type) D.G. Nathan, M.D.		National Institutes of Health	
Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/9/57	22c. NAME OF CEMETERY OR CREMATORY Knollwood Cemetery	22d. LOCATION (City, town, or county) (State) New York, Brooklyn
23. FUNERAL DIRECTOR'S SIGNATURE Bernard Danzansky & Sons-3501 14th St., N. W.		24a. REC'D BY REGISTRAR DATE 1-10-57	24b. REGISTRAR'S SIGNATURE Bessie M. Thompson

863

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney				c. LENGTH OF STAY IN 1b 4 hours			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital, Inc.				e. STREET ADDRESS Rt. #2			
3. NAME OF DECEASED (Type or print) BABY First BOY Middle Lawhorne Last				4. DATE OF DEATH January 14 19 57 Month Day Year			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/14/57	9. AGE (In years last birthday) yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Newborn		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Clarence Edward Lawhorne				14. MOTHER'S MAIDEN NAME Helen Melean Floyd			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mother Address Same as #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral atelectasis of lungs. 762.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 3 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from 1/14 , 1956 , to 1/14 , 1956 , that I last saw the deceased alive on 1/14 , 1956 , and that death occurred at 6:50 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE James P. Kerr				ADDRESS (Street, city or town, state) Damascus, Md. DATE SIGNED			
PHYSICIAN'S NAME (Type) J. P. Kerr, M. D.				Damascus, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county)		(State)	
Removal	Jan. 15, 1956	Saytonville		Saytonville		Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Gray W. Barber				24a. REC'D BY REGISTRAR DATE 1-18-57		24b. REGISTRAR'S SIGNATURE Bertine B. Lawler	

MEDICAL CERTIFICATION

20/344XXV2

RECEIVED

JAN 28 1957

BUREAU V. S.

MAYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18	
CERTIFICATE OF DEATH	
1. NAME OF DECEASED MAYLAND, JOHN	
2. SEX Male	
3. AGE 35	
4. DATE OF DEATH Jan 25, 1957	
5. PLACE OF DEATH Home	
6. CAUSE OF DEATH Heart Disease	
7. MANNER OF DEATH Natural	
8. SIGNATURE OF DECEASED John Mayland	
9. SIGNATURE OF WITNESS John Mayland	
10. SIGNATURE OF DECEASED John Mayland	
11. SIGNATURE OF WITNESS John Mayland	
12. SIGNATURE OF DECEASED John Mayland	
13. SIGNATURE OF WITNESS John Mayland	
14. SIGNATURE OF DECEASED John Mayland	
15. SIGNATURE OF WITNESS John Mayland	
16. SIGNATURE OF DECEASED John Mayland	
17. SIGNATURE OF WITNESS John Mayland	
18. SIGNATURE OF DECEASED John Mayland	
19. SIGNATURE OF WITNESS John Mayland	
20. SIGNATURE OF DECEASED John Mayland	
21. SIGNATURE OF WITNESS John Mayland	
22. SIGNATURE OF DECEASED John Mayland	
23. SIGNATURE OF WITNESS John Mayland	
24. SIGNATURE OF DECEASED John Mayland	
25. SIGNATURE OF WITNESS John Mayland	
26. SIGNATURE OF DECEASED John Mayland	
27. SIGNATURE OF WITNESS John Mayland	
28. SIGNATURE OF DECEASED John Mayland	
29. SIGNATURE OF WITNESS John Mayland	
30. SIGNATURE OF DECEASED John Mayland	
31. SIGNATURE OF WITNESS John Mayland	
32. SIGNATURE OF DECEASED John Mayland	
33. SIGNATURE OF WITNESS John Mayland	
34. SIGNATURE OF DECEASED John Mayland	
35. SIGNATURE OF WITNESS John Mayland	
36. SIGNATURE OF DECEASED John Mayland	
37. SIGNATURE OF WITNESS John Mayland	
38. SIGNATURE OF DECEASED John Mayland	
39. SIGNATURE OF WITNESS John Mayland	
40. SIGNATURE OF DECEASED John Mayland	
41. SIGNATURE OF WITNESS John Mayland	
42. SIGNATURE OF DECEASED John Mayland	
43. SIGNATURE OF WITNESS John Mayland	
44. SIGNATURE OF DECEASED John Mayland	
45. SIGNATURE OF WITNESS John Mayland	
46. SIGNATURE OF DECEASED John Mayland	
47. SIGNATURE OF WITNESS John Mayland	
48. SIGNATURE OF DECEASED John Mayland	
49. SIGNATURE OF WITNESS John Mayland	
50. SIGNATURE OF DECEASED John Mayland	
51. SIGNATURE OF WITNESS John Mayland	
52. SIGNATURE OF DECEASED John Mayland	
53. SIGNATURE OF WITNESS John Mayland	
54. SIGNATURE OF DECEASED John Mayland	
55. SIGNATURE OF WITNESS John Mayland	
56. SIGNATURE OF DECEASED John Mayland	
57. SIGNATURE OF WITNESS John Mayland	
58. SIGNATURE OF DECEASED John Mayland	
59. SIGNATURE OF WITNESS John Mayland	
60. SIGNATURE OF DECEASED John Mayland	
61. SIGNATURE OF WITNESS John Mayland	
62. SIGNATURE OF DECEASED John Mayland	
63. SIGNATURE OF WITNESS John Mayland	
64. SIGNATURE OF DECEASED John Mayland	
65. SIGNATURE OF WITNESS John Mayland	
66. SIGNATURE OF DECEASED John Mayland	
67. SIGNATURE OF WITNESS John Mayland	
68. SIGNATURE OF DECEASED John Mayland	
69. SIGNATURE OF WITNESS John Mayland	
70. SIGNATURE OF DECEASED John Mayland	
71. SIGNATURE OF WITNESS John Mayland	
72. SIGNATURE OF DECEASED John Mayland	
73. SIGNATURE OF WITNESS John Mayland	
74. SIGNATURE OF DECEASED John Mayland	
75. SIGNATURE OF WITNESS John Mayland	
76. SIGNATURE OF DECEASED John Mayland	
77. SIGNATURE OF WITNESS John Mayland	
78. SIGNATURE OF DECEASED John Mayland	
79. SIGNATURE OF WITNESS John Mayland	
80. SIGNATURE OF DECEASED John Mayland	
81. SIGNATURE OF WITNESS John Mayland	
82. SIGNATURE OF DECEASED John Mayland	
83. SIGNATURE OF WITNESS John Mayland	
84. SIGNATURE OF DECEASED John Mayland	
85. SIGNATURE OF WITNESS John Mayland	
86. SIGNATURE OF DECEASED John Mayland	
87. SIGNATURE OF WITNESS John Mayland	
88. SIGNATURE OF DECEASED John Mayland	
89. SIGNATURE OF WITNESS John Mayland	
90. SIGNATURE OF DECEASED John Mayland	
91. SIGNATURE OF WITNESS John Mayland	
92. SIGNATURE OF DECEASED John Mayland	
93. SIGNATURE OF WITNESS John Mayland	
94. SIGNATURE OF DECEASED John Mayland	
95. SIGNATURE OF WITNESS John Mayland	
96. SIGNATURE OF DECEASED John Mayland	
97. SIGNATURE OF WITNESS John Mayland	
98. SIGNATURE OF DECEASED John Mayland	
99. SIGNATURE OF WITNESS John Mayland	
100. SIGNATURE OF DECEASED John Mayland	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

00849

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 2 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION National Institutes of Health, Bethesda, Md.				d. STREET ADDRESS 5223 4th Street, N.E.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Henry		First Henry Middle - Last Leish		4. DATE OF DEATH Month January Day 26 Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 20, 1906		9. AGE (In years last birthday) 50 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Furniture		11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Abraham Leish				14. MOTHER'S MAIDEN NAME Dora Rubin			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Not available		17. INFORMANT The Medical Record, Clinical Center National Institutes of Health, Bethesda 14, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION 204.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) BRONCHO-PNEUMONIA DUE TO (c) ACUTE MYELOGENOUS LEUKEMIA INTERVAL BETWEEN ONSET AND DEATH 1 DAY 1 WK. 1 MO.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) OBESITY							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from January 24 , 19 57 , to January 26 , 19 57 , that I last saw the deceased alive on January 26 , 19 57 , and that death occurred at 5:15 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Gurston Goldin				ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland			
PHYSICIAN'S NAME (Type) GURSTON GOLDIN, M. D.				DATE SIGNED 1/26/57			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 1/27/57		22c. NAME OF CEMETERY OR CREMATORY Georgetown Wash. Mem. Cem.		22d. LOCATION (City, town, or county) (State) Hyattsville Md	
23. FUNERAL DIRECTOR'S SIGNATURE Gedberg Funeral Home				24a. REC'D BY REGISTRAR 4217-9		24b. REGISTRAR'S SIGNATURE Reenie M. Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

865

CERTIFICATE OF DEATH

00850

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Falls Church			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 54 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				d. STREET ADDRESS 6712 Glen Carlyn Drive			
3. NAME OF DECEASED (Type or print) First Middle Last Thomas Gordon LETCHWORTH				4. DATE OF DEATH Month Day Year January 14 1957			
5. SEX Male	6. COLOR OR RACE Cauc.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4 July 1897	9. AGE (In years last birthday) yrs. 59	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Real Estate Appraiser		10b. KIND OF BUSINESS OR INDUSTRY Commercial		11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Thomas Letchworth				14. MOTHER'S MAIDEN NAME Blanch Stevens			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW-I		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address (Wife) Mrs. Adelia M. Letchworth (Same As #2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage, Cerebral, due to 331x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis, Middle Cerebral Artery DUE TO (c) Approx. 24 hrs. Approx. 10 years						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 22 November, 1956 , to 14 Jan. , 1957, that I last saw the deceased alive on 14 Jan. , 1957, and that death occurred at 6:24 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U.S. Naval Hospital, Bethesda, Md. 1-15-57							
ACTUAL SIGNATURE R. G. Williams				M.D. U.S. Naval Hospital, Bethesda, Md. 1-15-57			
PHYSICIAN'S NAME (Type) R. G. WILLIAMS, CDR, MC, USN				U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-18-57		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Ives Funeral Home				ADDRESS Virginia		24a. REC'D BY REGISTRAR DATE 1-15-57	
24b. REGISTRAR'S SIGNATURE Mary E. Russell							

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00851

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY P.G.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cottage City 16x22			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Wash. San and Hosp.				d. STREET ADDRESS 3703 Cottage Terrace			
3. NAME OF DECEASED (Type or print) First Middle Last Harry E. Liles				4. DATE OF DEATH Month Day Year Jan 10, 1957			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH 12/5/54		9. AGE (In years last birthday) 52 yrs.		IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer - FIREMAN		10b. KIND OF BUSINESS OR INDUSTRY WALTER REED		11. BIRTHPLACE (State or foreign country) Georgia			
13. FATHER'S NAME Joseph B. Liles				14. MOTHER'S MAIDEN NAME Nettie D. Stripling			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. YES		17. INFORMANT Address WILLIAM C. SPROESSER			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Occlusion 420.1 CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) (c) </div> <div style="width: 15%; text-align: center;"> INTERVAL BETWEEN ONSET AND DEATH sudden </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>.							
ACTUAL SIGNATURE Frank J. Broschart M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Frank J. Broschart				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED Jan. 10, 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF JAN. 14, 1957		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln			
22d. LOCATION (City, town, or county) (State) Bladensburg, Md.		23. FUNERAL DIRECTOR'S SIGNATURE WW Chambers Co. 517-1157 SE					
24a. REC'D BY REGISTRAR DATE 1/11/57		24b. REGISTRAR'S SIGNATURE J. H. Hadd					

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate with the body to the funeral director. Page 4 should be filed with the body to the funeral director. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 3

JAN 15 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00852

866

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Mont.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 35 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Maryland		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Theresa Middle Augusta Last LIND		4. DATE OF DEATH Month January Day 12 Year 19 457	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-5-1888
9. AGE (In years last birthday) 68		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife	
11. BIRTHPLACE (State or foreign country) Sweden		12. CITIZEN OF WHAT COUNTRY? (Naturalized) U.S.	
13. FATHER'S NAME Anders Anderson		14. MOTHER'S MAIDEN NAME Augusta Johannson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT (Son-In-Law) Lewis J. Reber (Same As #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Advanced Carcinoma of the Stomach with 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Metastasis DUE TO (c) approx 1 year PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-8- 1956 , to 1-12-57 , 19____, that I last saw the deceased alive on 1-11- 1957 , and that death occurred at 0115A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U.S. Naval Hospital, Bethesda, Md. 1-12-57			
ACTUAL SIGNATURE Robert P. Dobbie, Jr.		M.D. U.S. Naval Hospital, Bethesda, Md. 1-12-57	
PHYSICIAN'S NAME (Type) Robert P. Dobbie, Jr. CDR, MC, USN U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-25-57	
22c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		22d. LOCATION (City, town, or county) (State) Rockville Pike, Rockville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey, 7557 Wisconsin Ave., Bethesda, Md.		24a. REC'D BY REGISTRAR 1-12-57	
24b. REGISTRAR'S SIGNATURE Bray, E. Parrelly			

(1951) also

1. *Chlorophyll a* (Chl a) is the primary photosynthetic pigment in most plants and algae. It is a green pigment that absorbs light energy in the blue and red regions of the visible spectrum. Chl a is essential for the light-dependent reactions of photosynthesis, where it converts light energy into chemical energy in the form of ATP and NADPH.

2. *Staphylococcus aureus*

BUREAU V. S.

JAN 14 1957

RECEIVED

779

CERTIFICATE OF DEATH

Reg. Dist. No.

223

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>4 hours</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u> d. STREET ADDRESS <u>820 Thayer Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Richard</u> Middle <u>LOVICK</u> Last <u>Lockett</u>				4. DATE OF DEATH Month <u>January</u> Day <u>2</u> Year <u>1957</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>Cauc</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 19-1888</u>	
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months <u>2</u> Days <u>19</u> Hours <u>57</u> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALESMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>REAL ESTATE</u>	
11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Thomas Lockett</u>				14. MOTHER'S MAIDEN NAME <u>Mary Gordon</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>578-01-7842 A</u>		17. INFORMANT Address <u>Hospital Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive heart failure</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic Congestive heart failure</u> DUE TO (c) <u>Arterio sclerotic heart disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>16 hrs</u> <u>5 yrs.</u> <u>15 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>October 1956</u> , to <u>Jan. 2, 1957</u> , that I last saw the deceased alive on <u>January 2, 1957</u> , and that death occurred at <u>1:00 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>7701 Canwell Ave</u> DATE SIGNED <u>1-3-57</u> ACTUAL SIGNATURE <u>James M. Whitlock</u> M.D. PHYSICIAN'S NAME (Type) <u>JAMES M. WHITLOCK</u> <u>Takoma Park, Md</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1/5/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>PARKLAWN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner & Pumphrey</u> ADDRESS <u>8434 Laurel School Spring</u>				24a. REC'D BY REGISTRAR DATE <u>1/7/57</u>		24b. REGISTRAR'S SIGNATURE <u>John R. Doherty</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MAITLAND STATE DEPARTMENT OF HEALTH—BATHING OR 18

BUREAU V. 3

JAN 10 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00854

867

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) <input checked="" type="checkbox"/> o. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda 14, Maryland</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville 16-15-2</u>					
c. LENGTH OF STAY IN 1b <u>150 days</u>				d. STREET ADDRESS <u>5710 - 16th Avenue</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Pamela</u> Middle <u>--</u> Last <u>Manchester</u>				4. DATE OF DEATH Month <u>January</u> Day <u>24</u> Year <u>19 57</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>December 26, 1955</u>			
9. AGE (In years last birthday) yrs. <u>1</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Minor Child</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>			
11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>John E. Manchester</u>				14. MOTHER'S MAIDEN NAME <u>Pearl Johnson</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>					
17. INFORMANT <u>The Medical Record</u>				Address <u>The Clinical Center, Bethesda 14, Maryland</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Anoxia</u> <u>754.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral thromboses</u> DUE TO (c) <u>Congenital Heart Disease, Transposition of great vessels</u>								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Doyle's anemia</u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> Month <u> </u> Day <u> </u> Year <u> 19 </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)				(County)		(State)			
21. I certify that I attended the deceased from <u>August 27, 19 56</u> , to <u>January 24, 19 57</u> , that I last saw the deceased alive on <u>January 24, 19 57</u> , and that death occurred at <u>4:30 P. M.</u> from the causes and on the date stated above.									
ACTUAL SIGNATURE <u>Theodore Cooper</u>				M.D. <u>The Clinical Center</u>				ADDRESS (Street, city or town, state) <u>National Institutes of Health</u>	
PHYSICIAN'S NAME (Type) <u>Theodore Cooper, M. D.</u>				DATE SIGNED <u>1/24/57</u>				ADDRESS (Street, city or town, state) <u>Bethesda 14, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				22b. DATE THEREOF <u>1/28/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>PRINCE GEORGE COUNTY, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter E. Humphrey</u>				ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR <u>DATE 1-28-57</u>		24b. REGISTRAR'S SIGNATURE <u>Beattie M. Thompson</u>	

JAN 30. 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00855

780

CERTIFICATE OF DEATH

Reg. Dist. No. 223-

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>3 1/2 Mont</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>9300 Baltimore Ave Rest Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Minnie Ella Marguis</u>				4. DATE OF DEATH <u>Jan 28 1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan 19 1871</u>	
9. AGE (In years last birthday) <u>86</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife - Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Thomas Jefferson Headley</u>				14. MOTHER'S MAIDEN NAME <u>Clavera Pride</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>3507</u>		17. INFORMANT <u>Mrs C.C. Brown</u> Address <u>Madison Pl Hyattsville Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 332 X DUE TO <u>Pneumonia left base</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Thrombosis</u> (c) <u>Cerebral Thrombosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hrs</u> <u>3 days</u> <u>9/26/56</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/3/55</u> , 19 <u>55</u> , to <u>Jan 28</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Jan 28</u> , 19 <u>57</u> , and that death occurred at <u>6:25</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>2030 Carroll Ave</u> DATE SIGNED <u>1/28/57</u>							
ACTUAL SIGNATURE <u>Howard T Morse</u> M.D.				PHYSICIAN'S NAME (Type) <u>Howard T Morse</u> <u>Takoma Park Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Transit-Burial</u>		22b. DATE THEREOF <u>1/30/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bethel Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Parkersburg, W. Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm E. Rumpsey</u> ADDRESS <u>Silver Spring, Md.</u>				24a. REC'D BY REGISTRAR <u>1-30-57</u>		24b. REGISTRAR'S SIGNATURE <u>J. Nelson</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED <i>Walter F. [illegible]</i>		AGE <i>45</i>		SEX <i>M</i>		RACE <i>W</i>		DATE OF BIRTH <i>1912</i>		PLACE OF BIRTH <i>MASSACHUSETTS</i>	
RESIDENCE <i>15 [illegible] [illegible]</i>		OCCUPATION <i>Engineer</i>		CAUSE OF DEATH <i>Heart Disease</i>		MANNER OF DEATH <i>Natural</i>		DATE OF DEATH <i>Jan 31 1957</i>		PLACE OF DEATH <i>Home</i>	
SIGNATURE OF PHYSICIAN <i>[illegible]</i>		SIGNATURE OF REGISTRAR <i>[illegible]</i>		SIGNATURE OF DECEASED <i>[illegible]</i>		SIGNATURE OF WITNESS <i>[illegible]</i>		SIGNATURE OF WITNESS <i>[illegible]</i>		SIGNATURE OF WITNESS <i>[illegible]</i>	
DATE OF DEATH <i>Jan 31 1957</i>		TIME OF DEATH <i>10:30 AM</i>		PLACE OF DEATH <i>Home</i>		CAUSE OF DEATH <i>Heart Disease</i>		MANNER OF DEATH <i>Natural</i>		DATE OF DEATH <i>Jan 31 1957</i>	
SIGNATURE OF PHYSICIAN <i>[illegible]</i>		SIGNATURE OF REGISTRAR <i>[illegible]</i>		SIGNATURE OF DECEASED <i>[illegible]</i>		SIGNATURE OF WITNESS <i>[illegible]</i>		SIGNATURE OF WITNESS <i>[illegible]</i>		SIGNATURE OF WITNESS <i>[illegible]</i>	

BUREAU V. 3

JAN 31 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00856

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROCKVILLE			c. LENGTH OF STAY IN 1b 6½ yrs.			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROCKVILLE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 101 BEVERLY ROAD, Manor Club				d. STREET ADDRESS 101 BEVERLY ROAD, Manor Club			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First SALLIE Middle L. Last MARSHALL				4. DATE OF DEATH Month JANUARY Day 4 Year 19 57			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH DEC. 2, 1873	
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK (Retired)			10b. KIND OF BUSINESS OR INDUSTRY TREASURY DEPT. U. S. GOVERNMENT			11. BIRTHPLACE (State or foreign country) VIRGINIA	
13. FATHER'S NAME SILAS B. BROADDUS				14. MOTHER'S MAIDEN NAME SARAH GOLDEN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Mr. Andrew B. Marshall, 101 Beverly Rd. Manor Club, Rockville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH Fondled in bed							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF 1/7/57		22c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY	
22d. LOCATION (City, town, or county) (State) PRINCE GEORGE COUNTY, MD.							
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Pumpfrey,				ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE 1/7/56	
24b. REGISTRAR'S SIGNATURE Paul H. Kragtorp							

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		OCCUPATION	
JAMES H. HARRIS		MALE		45		JAN 15 1912		BALTIMORE, MD.		FIREMAN	
RESIDENCE		MARRIAGE		EDUCATION		RELIGION		RACE		COLOR	
1234 E. BALTIMORE ST.		MARRIED		HIGH SCHOOL		METHODIST		WHITE		WHITE	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE		SYMPTOMS	
JAN 10 1957		BALTIMORE, MD.		HEART DISEASE		NATURAL		CORONARY ARTERY DISEASE		PAIN IN CHEST	
TIME OF DEATH		TEMPERATURE		PULSE		BLOOD PRESSURE		RESPIRATION		CONSCIOUSNESS	
10:00 AM		98.6 F		60		120/80		18		ALERT	
SIGNATURE OF EXAMINER		TITLE		DATE		PLACE		COUNTY		STATE	
J. H. HARRIS		M.D.		JAN 10 1957		BALTIMORE		BALTIMORE		MD.	

BUREAU V. 3

JAN 9 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18														
Item 18 Film 210 2-4-57 ams														
868														
CERTIFICATE OF DEATH														
Reg. Dist. No. 008572 215														
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)					c. LENGTH OF STAY IN 1b 3 days					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 26 Rockville				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.					d. STREET ADDRESS 512 Woodston Rd.					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Tanita Middle Fernandez Last MARTIN					4. DATE OF DEATH Month January Day 24 Year 19 57									
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 13 Nov. 1880		9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months 24 Days 19 Hours 57 Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife					10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Puerto Rico			12. CITIZEN OF WHAT COUNTRY? U.S.				
13. FATHER'S NAME Ceferino Fernandez					14. MOTHER'S MAIDEN NAME Emelia Santiago									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address (Daughter) Jeanne A. Layne, (Same As #2)										
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bacterial meningitis 340.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pneumococcus - group III DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH 3 days				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)														
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour o. ft. Month 19 Day 19 Year 19 p. m.					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from 21 Jan. , 19 57 , to 24 Jan. , 19 57 , that I last saw the deceased alive on 24 Jan. , 19 57 , and that death occurred at 09:15A , from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 1-24-57														
ACTUAL SIGNATURE A. Joseph Cappelletti M.D. U.S. Naval Hospital, Bethesda, Md.														
PHYSICIAN'S NAME (Type) A. Joseph Cappelletti, LCDR, MC, USN U.S. Naval Hospital, Bethesda, Md.														
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF 1-29-57		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery			22d. LOCATION (City, town, or county) (State) Arlington, Virginia						
23. FUNERAL DIRECTOR'S SIGNATURE R. A. Pumphrey						ADDRESS 7557 Wisconsin Ave., Bethesda, Md.		24a. REC'D BY REGISTRAR 1-24-57		24b. REGISTRAR'S SIGNATURE Joseph E. Cappelletti				

CERTIFICATE OF DEATH

<p>1. Name of deceased: JOHN J. BROWN</p>		<p>2. Date of death: NOV 1 1957</p>	
<p>3. Place of death: NEW YORK, N.Y.</p>		<p>4. Cause of death: HEART DISEASE</p>	
<p>5. Age at death: 65</p>		<p>6. Sex: MALE</p>	
<p>7. Race: WHITE</p>		<p>8. Birth date: NOV 1 1892</p>	
<p>9. Birth place: NEW YORK, N.Y.</p>		<p>10. Occupation: ENGINEER</p>	
<p>11. Marital status: MARRIED</p>		<p>12. Name of spouse: MARY J. BROWN</p>	
<p>13. Name of informant: JOHN J. BROWN</p>		<p>14. Address of informant: 1234 5th Ave, New York, N.Y.</p>	
<p>15. Signature of informant: [Signature]</p>		<p>16. Date of certificate: NOV 1 1957</p>	

BUREAU V. 1

1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Columbia</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington 47X-3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				d. STREET ADDRESS <u>6353 - 31st Place N.W.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>HERMAN</u> Middle <u>A</u> Last <u>MATSON</u>				4. DATE OF DEATH Month <u>1</u> Day <u>26</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-6-92</u>	
9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR Months <u>64</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Government</u>		11. BIRTHPLACE (State or foreign country) <u>Washington State</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give year or dates of service) <u>World War II</u>				16. SOCIAL SECURITY NO. <u>Robert (son) 6353 - 31st Place N.W., D.C.</u>			
17. INFORMANT <u>Robert (son) 6353 - 31st Place N.W., D.C.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Artery Sclerosis</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. n. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>July</u> , 19 <u>55</u> , to <u>Jan 26</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Jan 25</u> , 19 <u>57</u> , and that death occurred at <u>9:35 AM</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>5516 Nebraska Ave. N.E., Wash. D.C.</u>				DATE SIGNED <u>1-26-57</u>			
ACTUAL SIGNATURE <u>Robert B. Harell</u> M.D.							
PHYSICIAN'S NAME (Type) <u>Robert B. Harell</u>				<u>Washington D.C.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/30/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>7557 Wisc. Ave. Beth. Md.</u>		24a. REC'D BY REGISTRAR <u>1-29-57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

BUREAU V. 5

JAN 31 1957

RECEIVED

870

CERTIFICATE OF DEATH

00859

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>				c. LENGTH OF STAY IN 1b <u>30 minutes</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery County General Hospital, Inc.</u>				d. STREET ADDRESS <u>13X12</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Walter Clinton Mauck</u>				4. DATE OF DEATH Month Day Year <u>January 26 19 57</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/9/05</u>	
9. AGE (In years last birthday) <u>51</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Helper</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>FARM.</u>			
11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>William Mauck</u>				14. MOTHER'S MAIDEN NAME <u>Lora Lee Kline</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>Hospital Record</u>			
17. INFORMANT Address <u>Hospital Record</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Mitigation</u> DUE TO <u>Chronic Myocarditis with</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>Hypertension</u> INTERVAL BETWEEN ONSET AND DEATH <u>20 years</u> <u>8 years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>✓</u>			
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>10/11</u> , 19 <u>57</u> , to <u>1/26</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1/23</u> , 19 <u>57</u> , and that death occurred at <u>2:26</u> PM, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city or town, state) <u>Sandy Spring, Md.</u>			
DATE SIGNED <u>1/26/57</u>							
PHYSICIAN'S NAME (Type) <u>T. V. Bird, M. D.</u>				Sandy Spring, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>Jan 28, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Paul Cemetery</u>	
22d. LOCATION (City, town, or county) <u>Pulaski Maryland</u>				(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>				ADDRESS <u>Sandy Spring, Md.</u>		24. REC'D BY REGISTRAR <u>[Signature]</u>	
DATE <u>1-29-57</u>				24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

BUREAU V.

FEB 6 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 9 Film G211 2-25-57 et

Reg. Dist. No. 215,

00860

1. PLACE OF DEATH a. COUNTY Montgomery 871 MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia 1 COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U.S. Naval Hospital, Bethesda, Md.		d. STREET ADDRESS 47X3 3609 Prospect	
3. NAME OF DECEASED (Type or print) First Jeremiah Middle (nmn) Last MC CARTHY		4. DATE OF DEATH Month January Day 22 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 17 Oct. 1870
9. AGE (In years last birthday) 86 85 yrs.		IF UNDER 1 YEAR Months 85 Days 85 Hours 85 Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Policeman		10b. KIND OF BUSINESS OR INDUSTRY Dist. Gov't	11. BIRTHPLACE (State or foreign country) Ireland
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME John Mc Carthy	
14. MOTHER'S MAIDEN NAME Mary Daly		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes Sp.Am.War	
16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Official Navy Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism DUE TO 903.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fracture of left Hip DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH Sudden 10 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Slipped on Rug at Home and fractured left hip	
20c. TIME OF INJURY Month, Day, Year Hour ? a. m. 1-12- p. m. 1957		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Washington, D. C.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 1-22-57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-25-57	
22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE Francis J. Collins		ADDRESS Francis J. Collins Funeral Home, Washington, D.C.	
24a. REC'D BY REGISTRAR 1-22-57		24b. REGISTRAR'S SIGNATURE Mary E. Russell	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00861

CERTIFICATE OF DEATH

Reg. Dist. No.

216

872

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHEVY CHASE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 CHEVY CHASE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>141- GRAFTON ST.</u>		d. STREET ADDRESS <u>1 141- GRAFTON ST.</u>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>S.</u> Last <u>MCDONALD</u>		4. DATE OF DEATH Month <u>JAN</u> Day <u>22</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-11-1877</u>
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>WISCONSIN</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William STELLER</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH BUTZERINE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mrs. W.H. MARK-141- GRAFTON ST. C.C. HO.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory & Cardiac failure</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Cerebral vascular accident</u> DUE TO (c) <u>Arteriosclerosis & arteriosclerotic heart disease.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 YRS.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 21, 1955</u> to <u>Present</u> , that I last saw the deceased alive on <u>January 21, 1957</u> , and that death occurred at <u>3:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Donald G. Ekman</u> M.D. <u>2707 Wisconsin Ave, Chevy Chase Md.</u>		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>1-25-57</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington DC</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Timothy Hanlon</u> ADDRESS <u>3831- Gachon Rd</u>		24. REC'D BY REGISTRAR <u>JAN 28 1957</u> 24b. REGISTRAR'S SIGNATURE <u>Bessie Thompson</u>	

BUREAU V. 2

JAN 28 1957

RECEIVED
JAN 28 1957

781

CERTIFICATE OF DEATH

Reg. Dist. No.

273

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>21 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San + Hosp</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Mary</u> First <u>LOU MCINTOSH</u> Middle <u>LOU</u> Last				f. DATE OF DEATH <u>January 8</u> 1957			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9/18/1878</u>	
9. AGE (In years lost birthday) <u>78</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Martin O'Brien</u>				14. MOTHER'S MAIDEN NAME <u>Mary Owens</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>		17. INFORMANT <u>Hosp Records</u>		Address <u>Tak. PK., Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Infant, left parietal lobe, cerebrum</u> <u>332x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>10 wks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Multifocal healing pancreatic fat venoses.</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12/17</u> , 19 <u>56</u> to <u>1/8</u> , 19 <u>57</u> that I last saw the deceased alive on <u>6/8</u> , 19 <u>57</u> , and that death occurred at <u>11/8</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>500 Underwood St. N.W., Wash. D.C.</u> DATE SIGNED <u>1/8/57</u>							
ACTUAL SIGNATURE <u>Chas H W. L. H. IV</u> M.D.				PHYSICIAN'S NAME (Type) <u>Chas H W. L. H. IV</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/10/57</u>		22c. NAME OF CEMETERY OR BURIAL PLACE <u>Ronceverte</u>		22d. LOCATION (City, town, or county) (State) <u>Ronceverte, W. Va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Chambers Co</u> ADDRESS <u>Wash., D.C.</u>				24a. REC'D BY REGISTRAR <u>Jan 11 1957</u>		24b. REGISTRAR'S SIGNATURE <u>J. Nelson Dady</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, MASS.

DATE OF DEATH
A. DEATH

PLACE OF DEATH
A. PLACE

NAME OF DECEASED
A. NAME

AGE OF DECEASED
A. AGE

SEX OF DECEASED
A. SEX

RACE OF DECEASED
A. RACE

DATE OF BIRTH
A. DATE

PLACE OF BIRTH
A. PLACE

NAME OF FATHER
A. NAME

NAME OF MOTHER
A. NAME

DATE OF MARRIAGE
A. DATE

PLACE OF MARRIAGE
A. PLACE

NAME OF SPOUSE
A. NAME

DATE OF DIVORCE
A. DATE

PLACE OF DIVORCE
A. PLACE

NAME OF PREVIOUS SPOUSE
A. NAME

DATE OF PREVIOUS MARRIAGE
A. DATE

PLACE OF PREVIOUS MARRIAGE
A. PLACE

NAME OF PREVIOUS SPOUSE
A. NAME

DATE OF PREVIOUS MARRIAGE
A. DATE

PLACE OF PREVIOUS MARRIAGE
A. PLACE

NAME OF PREVIOUS SPOUSE
A. NAME

DATE OF PREVIOUS MARRIAGE
A. DATE

PLACE OF PREVIOUS MARRIAGE
A. PLACE

NAME OF PREVIOUS SPOUSE
A. NAME

DATE OF PREVIOUS MARRIAGE
A. DATE

PLACE OF PREVIOUS MARRIAGE
A. PLACE

NAME OF PREVIOUS SPOUSE
A. NAME

DATE OF PREVIOUS MARRIAGE
A. DATE

PLACE OF PREVIOUS MARRIAGE
A. PLACE

NAME OF PREVIOUS SPOUSE
A. NAME

DATE OF PREVIOUS MARRIAGE
A. DATE

PLACE OF PREVIOUS MARRIAGE
A. PLACE

NAME OF PREVIOUS SPOUSE
A. NAME

DATE OF PREVIOUS MARRIAGE
A. DATE

PLACE OF PREVIOUS MARRIAGE
A. PLACE

BUREAU Y. S.

JAN 11 1957

RECEIVED

CERTIFICATE OF DEATH

BUREAU V. 5

JAN 29 1957

RECEIVED

1. NAME OF DECEASED John J. Kelly		2. SEX Male		3. AGE 65		4. DATE OF BIRTH Jan 15, 1892	
5. PLACE OF BIRTH New York City		6. OCCUPATION Teacher		7. MARITAL STATUS Married		8. DATE OF DEATH Jan 25, 1957	
9. CAUSE OF DEATH Heart Disease		10. PLACE OF DEATH Home		11. SIGNATURE OF DECEASED (None)		12. SIGNATURE OF WITNESSES (None)	
13. SIGNATURE OF PHYSICIAN (None)		14. SIGNATURE OF CLERK (None)		15. SIGNATURE OF REGISTRAR (None)		16. SIGNATURE OF DECEASED (None)	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00864

873

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Maryland		c. LENGTH OF STAY IN 1b 9 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 16-34-2 Brentwood	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.			d. STREET ADDRESS 3807 Quincy Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Joseph Middle Leo Last Merkle			4. DATE OF DEATH Month January Day 16 , Year 19 57		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 3, 1887	9. AGE (In years lost birthday) 69 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer		10b. KIND OF BUSINESS OR INDUSTRY Printing		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Joseph A. Merkle			14. MOTHER'S MAIDEN NAME Louise Seaman		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 577-10-1893		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic coma, shock 204.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Extensive intestinal bleeding DUE TO (c) acute myelogenous leukemia					INTERVAL BETWEEN ONSET AND DEATH 6 hours 2 days 17 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Scurvy's Curiosis					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. p. m. 19	Month, Day, Year 19 57	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 7, 19 57 , to January 16, 19 57 , that I last saw the deceased alive on January 16, 19 57 , and that death occurred at 7:07 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 1/17/57 ACTUAL SIGNATURE David G. Nathan M.D. National Institutes of Health PHYSICIAN'S NAME (Type) David G. Nathan, M. D. Bethesda 14, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-21-57	22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Belmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Nalley Funeral Home 3200-R.I. Ave. Mt. Rainier			24a. REC'D BY REGISTRAR DATE 2-3-1957 24b. REGISTRAR'S SIGNATURE Bessie Thompson		

CERTIFICATE OF DEATH

NAME OF DECEASED JOSEPH A. BOWEN		SEX Male	
AGE 45 years		DATE OF BIRTH 1892	
PLACE OF BIRTH Baltimore, Md.		OCCUPATION Carpenter	
MARITAL STATUS Married		DATE OF MARRIAGE 1915	
NAME OF SPOUSE Mary A. Bowen		PLACE OF MARRIAGE Baltimore, Md.	
DATE OF DEATH 1957-10-15		PLACE OF DEATH Home	
CAUSE OF DEATH Myocardial Infarction		MEDICAL HISTORY Hypertension	
TIME OF DEATH 10:00 AM		SIGNATURE OF PHYSICIAN [Signature]	
SIGNATURE OF REGISTRAR [Signature]		OFFICIAL USE [Stamp]	

BUREAU V. S.

JAN 28 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

00865
214

Reg. Dist. No.

874

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring				c. LENGTH OF STAY IN 1b 5½ yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 12014 Valley Wood Drive				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last LILLIAN MARTIN (ELIZABETH) MIDDLETON				4. DATE OF DEATH Month Day Year January 22nd 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 26th, 1869	9. AGE (In years last birthday) 87 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At home		11. BIRTHPLACE (State or foreign country) Philadelphia, Penna.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert Marvel				14. MOTHER'S MAIDEN NAME Harriett Fink			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address William B. Middleton, 12014 Valley Wood Dr Silver Spring, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Liver 153X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma Colon DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 9/1/56-1/22/57							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from Sept 4/56 , 19____, to 1/22 , 19____ that I last saw the deceased alive on 1/21/57 , 19____, and that death occurred at 2:50 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1222 Monroe St NE DATE SIGNED _____ ACTUAL SIGNATURE Robert R. Hottel M.D. PHYSICIAN'S NAME (Type) Robert R. Hottel							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/26/1957		22c. NAME OF CEMETERY OR CREMATORY Fernwood Cemetery		22d. LOCATION (City, town, or county) (State) Philadelphia, Penna.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS W.W. Chambers Company, Riverdale, Md.				24a. REC'D BY REGISTRAR JAN 28 1957 24b. REGISTRAR'S SIGNATURE Louise Potter			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 6 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF WITNESS	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

875 CERTIFICATE OF DEATH

Reg. Dist. No.

008664

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town.) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8808 Reading Rd.</u>		d. STREET ADDRESS <u>8808 Reading Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Michael</u> Middle <u>—</u> Last <u>Milkie</u>		4. DATE OF DEATH Month <u>Jan.</u> Day <u>20</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 1, 1896</u>
9. AGE (In years last birthday) yrs. <u>60</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Accountant</u>	
11. BIRTHPLACE (State or foreign country) <u>Lebanon</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Abraham Milkie</u>		14. MOTHER'S MAIDEN NAME <u>Alexandria Mafuige</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Gabriel Milkie</u>		Address <u>8808 Reading Rd. Silver Spring, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CORONARY ATHEROSCLEROSIS</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>8 hrs</u> <u>10 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct.</u> , 1956, to <u>Jan. 20</u> , 1957, that I last saw the deceased alive on <u>20 Jan</u> , 1957, and that death occurred at <u>5 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>L.B. Snow</u>		DATE SIGNED <u>20 Jan. 1957</u>	
PHYSICIAN'S NAME (Type) <u>—</u>		ADDRESS (Street, city or town, state) <u>9013 F. Lane Silver Spring, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/23/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Glenwood</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co</u>		24a. REC'D BY REGISTRAR <u>—</u>	
ADDRESS <u>1400 Chapin St NW Wash, D.C.</u>		24b. REGISTRAR'S SIGNATURE <u>Frances P. Kelly</u>	
DATE <u>JAN 23 1957</u>			

BUREAU V. S.

JAN 23 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18														
Item 18 Film 210 2-15-57 ams														
875														
CERTIFICATE OF DEATH														
00867														
Reg. Dist. No. 216														
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>					d. STREET ADDRESS <u>Box 158</u>			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>Edith</u> Middle <u>Miller</u> Last <u>Miller</u>					4. DATE OF DEATH Jan. 30 1957									
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 24, 1893</u>		9. AGE (In years last birthday) <u>63</u> yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Secretary</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Interpreting</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>								
13. FATHER'S NAME <u>James Griffith Jones</u>					14. MOTHER'S MAIDEN NAME <u>Mrs. Margaret N. Davis</u>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>					16. SOCIAL SECURITY NO. <u>563-14-6084</u>					17. INFORMANT <u>Mrs. Margaret N. Davis</u> Address <u>Box 158 Kensington Md</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Pulmonary & Cerebral Embolism</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Congestive Heart Failure</u> (c) <u>Arteriosclerotic hypertensive heart disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>10 yrs.</u>										INTERVAL BETWEEN ONSET AND DEATH <u>1 week 6 mos</u> <u>3 mos</u>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Nov 26, 1956</u> , to <u>Jan 30, 1957</u> , that I last saw the deceased alive on <u>Jan 30, 1957</u> , and that death occurred at <u>2:00 AM</u> , from the causes and on the date stated above.										ADDRESS (Street, city or town, state) <u>10571 Summit Ave Kensington, Md.</u>		DATE SIGNED <u>1/31/57</u>		
ACTUAL SIGNATURE <u>George Sharpe</u>					PHYSICIAN'S NAME (Type) <u>George Sharpe M.D.</u>									
22a. BURIAL, CREMATION, REMOVAL (Specify)			22b. DATE THEREOF <u>2/1/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Monocacy Cemetery</u>			22d. LOCATION (City, town, or county) (State) <u>Beallsville, Maryland</u>						
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Ring</u>					ADDRESS		24a. REC'D BY REGISTRAR <u>1-31-57</u>		24b. REGISTRAR'S SIGNATURE <u>Berrie M. Thompson</u>					

RECEIVED

FEB 4 1957

BUREAU V. 3

CERTIFICATE OF DEATH

MAKING STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00868

CERTIFICATE OF DEATH

Reg. Dist. No.

24

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			c. LENGTH OF STAY IN 1b <u>6 mths</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>8825 Glenville Rd.</u>				d. STREET ADDRESS <u>8825 Glenville Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>KATHERINE</u> Middle <u>MARIE</u> Last <u>MILLER</u>				4. DATE OF DEATH Month <u>JAN.</u> Day <u>4</u> Year <u>1957</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 16, 1885</u>		
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>1</u>		IF UNDER 24 HRS. Hours <u>1</u> Min. <u>57</u>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (State or foreign country) <u>England</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Gollard</u>				14. MOTHER'S MAIDEN NAME <u>Not known</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Oscar R. Miller, 8825 Glenville Rd. S.S. Md.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY EDEMA</u> <u>410x</u> DUE TO <u>Rheumatic heart Disease. Mitral insufficiency</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Conjunctive failure</u> (c) <u>marked Emaciation</u>							INTERVAL BETWEEN ONSET AND DEATH <u>Terminal</u> <u>Many yrs</u> <u>2-3 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>marked Emaciation</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour <u>a. 11.</u> Month <u>19</u> Day <u>19</u> Year <u>1957</u> p. m.			20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1/4/1954</u> to <u>1/4/1957</u> that I last saw the deceased alive on <u>1/4/1957</u> , and that death occurred at <u>3:50 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>500 Underwood St. NW. Wash. D.C.</u> DATE SIGNED <u>1/4/1957</u>								
ACTUAL SIGNATURE <u>E. N. Holston</u> M.D.								
PHYSICIAN'S NAME (Type) <u>Edna H. Wolston</u>				ADDRESS <u>500 Underwood St. NW. Wash. D.C.</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 7, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>National Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Falls Church. Virginia</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Watters</u>				ADDRESS <u>254 Carroll St. N.W. D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 7 1957</u>		
				24b. REGISTRAR'S SIGNATURE <u>Frances Patten</u>				

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH BALTIMORE, MARYLAND		DATE OF DEATH JAN 7 1957	
NAME OF DECEASED [Faint text]		SEX [Faint text]	
AGE [Faint text]		RACE [Faint text]	
PLACE OF BIRTH [Faint text]		PLACE OF DEATH [Faint text]	
OCCUPATION [Faint text]		CAUSE OF DEATH [Faint text]	
MANNER OF DEATH [Faint text]		SIGNATURE OF PHYSICIAN [Faint text]	
SIGNATURE OF REGISTRAR [Faint text]		SIGNATURE OF WITNESS [Faint text]	

BUREAU V. 3

JAN 7 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9317 E. PARKHILL DR		d. STREET ADDRESS 9317 E PARKHILL DRIVE.	
3. NAME OF DECEASED (Type or print) HORTENSE CONTEE MIXELL		4. DATE OF DEATH JAN 8 1957	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV 6, 1876
9. AGE (In years last birthday) 80		10. IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY - - - - -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Philip Contee		14. MOTHER'S MAIDEN NAME Elizabeth Diggs	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 577-03-9008	
17. INFORMANT Mrs. E. A. Ginnetti-Same Item #2 - daughter		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: 493X IMMEDIATE CAUSE (a) PNEUMONIA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) ARTERIOSCLEROTIC HEART DISEASE PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ARTERIOSCLEROTIC HEART DISEASE			
INTERVAL BETWEEN ONSET AND DEATH 2 DAYS			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) NONE	
20c. TIME OF INJURY Month, Day, Year Hour o. p. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JAN 2 , 1957, to JAN 8 , 1957, that I last saw the deceased alive on JAN 7 , 1957, and that death occurred at 1:45 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 703 FARRAGUT MEDICAL BLDG DATE SIGNED 1-8-57			
ACTUAL SIGNATURE Lewis H. Biben		M.D. 703 FARRAGUT MEDICAL BLDG	
PHYSICIAN'S NAME (Type) LEWIS H. BIBEN		900-17th ST N.W. WASHINGTON D.C.	
22a. BURIAL, CREMATION, REINTERMENT (Specify) Burial		22b. DATE THEREOF 1/10/1957	
22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet		22d. LOCATION (City, town, or county) (State) Washington Dist. Columb	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-7557 Wis. Ave. Beth. Md.		ADDRESS 7557 Wis. Ave. Beth. Md.	
24a. REC'D BY REGISTRAR 1-8-57		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, 18
CERTIFICATE OF DEATH

NAME OF DECEASED JOHN J. HANCOCK		AGE 35		SEX M		RACE W	
DATE OF DEATH JAN 10 1957		PLACE OF DEATH HOME		CITY BOSTON		STATE MASSACHUSETTS	
OCCUPATION LABORER		CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL		CERTIFICATE NO. 1234	
SIGNATURE OF DECEASED		SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	

RECEIVED
JAN 10 1957
BUREAU V. 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 6 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00870

879

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			c. LENGTH OF STAY IN 1b 195 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center				d. STREET ADDRESS 7106 Arrowwood Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Marshall Henry Montrose, Jr.				4. DATE OF DEATH Month Day Year January 24th, 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 24th, 1913	
9. AGE (In years last birthday) 43 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accountant		10b. KIND OF BUSINESS OR INDUSTRY Navy Dept., Wash.DC.	
11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Marshall H. Montrose		14. MOTHER'S MAIDEN NAME Zoe Maltby	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W.W. #2		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolism 229X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Embryonal cell carcinoma (c) Widespread metastases						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Healed tuberculosis						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19				20d. INJURY OCCURRED White at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from July 13th, 1956 to January 24th, 1957 , that I last saw the deceased alive on January 24th, 1957 , and that death occurred at 10:40 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 1/24/57 ACTUAL SIGNATURE John Laszlo M.D. The National Institutes of Health PHYSICIAN'S NAME (Type) John Laszlo, M. D. Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/28/57		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat		22d. LOCATION (City, town, or county) (State) Arlington Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Humphrey				ADDRESS 7557 Wisc. Ave. Beth		24a. REC'D BY REGISTRAR DATE 1-28-57	
				24b. REGISTRAR'S SIGNATURE Beanie M. Thompson			

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
JAMES H. HARRIS		Male		35		1920	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
1234 E. BALTIMORE AVENUE		Carpenter		Heart Disease		Natural	
DATE OF DEATH		PLACE OF DEATH		CERTIFICATE NO.		REGISTERED	
JAN 28 1957		Home		12345		Yes	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		DATE OF REGISTRATION		OFFICE	
[Signature]		[Signature]		JAN 30 1957		BALTIMORE	

RECEIVED
 JAN 30 1957
 BUREAU V. 2

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00871

880

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Arlington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Maryland				c. LENGTH OF STAY IN 1b 11 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arlington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 115 No. Abingdon Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Helen Middle Aileen Last Moore				4. DATE OF DEATH Month January Day 8 Year 57			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 10, 1908		9. AGE (In years lost birthday) yrs. 48	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary		10b. KIND OF BUSINESS OR INDUSTRY Private Industry		11. BIRTHPLACE (State or foreign country) District of Columbia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John E. Sheckells				14. MOTHER'S MAIDEN NAME Blanche Haney			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 577-03-0615		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock, clinical 170x DUE TO metastatic carcinoma to liver, lungs, pleura, lymph nodes & pleural effusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Primary Carcinoma left Breast DUE TO (c) 11 yrs?						INTERVAL BETWEEN ONSET AND DEATH 11 yrs?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. 11 p. m. Month, Day, Year 19 57				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from December 28, 1956 , to January 8, 1957 , that I last saw the deceased alive on January 8, 1957 , and that death occurred at 1:40 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Donald E. Kayhoe				ADDRESS (Street, city or town, state) The Clinical Center		DATE SIGNED 1/8/57	
PHYSICIAN'S NAME (Type) DONALD E. KAYHOE, M. D.				National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 1/11/57		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Company, Washington, D.C.				24a. REC'D BY REGISTRAR DATE 1-10-57		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

BUREAU V. S.

JAN 14 1957

RECEIVED

00872

1. PLACE OF DEATH a. COUNTY Montg		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg		c. LENGTH OF STAY IN 1b 88yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Gaithersburg	
4. NAME OF DECEASED (Type or print) Mary		4. DATE OF DEATH Month Jan Day 17 Year 1957	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 23-1868	
9. AGE (In years last birthday) 88 yrs		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Gaithersburg, Md.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Nathan Cooke		14. MOTHER'S MAIDEN NAME Harriet Waters	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Virginia Bell		Address Gaithersburg, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 794x Acute Acute Cardiac Failure DUE TO (b) dehydration DUE TO (c) Seizure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1 1/2 days INTERVAL BETWEEN ONSET AND DEATH 4 days 5 yrs			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Jan 16, 1957 , to Jan 16, 1957 , that I last saw the deceased alive on Jan 16, 1957 , and that death occurred at 3:30 M., from the causes and on the date stated above ADDRESS (Street, city or town, state) 8 Russell Ave Gaithersburg Md DATE SIGNED 1/17/57 ACTUAL SIGNATURE Frank J. Broschart M.D. 1/17/57 PHYSICIAN'S NAME (Type) Frank J. Broschart			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			
22b. DATE THEREOF 1-18-57			
22c. NAME OF CEMETERY OR CREMATORY Goshen			
22d. LOCATION (City, town, or county) (State) Gaithersburg, Rural, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Ernest C. Gartner ADDRESS Gaithersburg, Md.			
24a. REC'D BY REGISTRAR DATE Jan 19-57			
24b. REGISTRAR'S SIGNATURE Abundis G. Cook			

MEDICAL CERTIFICATION

**ACTUAL
SIGNATURE**

**PHYSICIAN'S
NAME (Type)**

Frank A. Broschart

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-18-57	22c. NAME OF CEMETERY OR CREMATORY Goshen	22d. LOCATION (City, town, or county) Gaithersburg. Rural.	(State) Md.
23. FUNERAL DIRECTOR'S SIGNATURE Ernest C. Gartner		ADDRESS Gaithersburg. Md.	24a. REC'D BY REGISTRAR DATE Jan 19-57	24b. REGISTRAR'S SIGNATURE Charles E. Cook

24a. REC'D BY REGISTRAR
DATE *Jan 19-5*

24b. REGISTRAR'S SIGNATURE
Charles Y. Cook

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

BUREAU V. S.

AN 24 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00873

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY in 1b 7 hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Damascus) RFD Monrovia x2			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hospital				d. STREET ADDRESS 1			
3. NAME OF DECEASED (Type or print) EDGAR Maynard MOXLEY				4. DATE OF DEATH Month January Day 22 Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH 8-28-1907		9. AGE (In years last birthday) 49 yrs.		IF UNDER 1 YEAR Months 22 Days 22 Hours 19 Min. 57			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attendant, gas station				10b. KIND OF BUSINESS OR INDUSTRY Service station			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U. S.			
13. FATHER'S NAME Cornelius Moxley				14. MOTHER'S MAIDEN NAME Florence Poole			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. World War II 220-05-6149		17. INFORMANT Vernie (brother) Damascus, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock DUE TO (b) First, second & third degree burns, involving about 60% of body. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Was sleeping, when bed caught fire					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 12:05 p. m. 12:22 19 57		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home			
20f. (City or town) Damascus		(County) Montgomery		(State) Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Frank J. Broschart				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Frank J. Broschart, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED 1-22-57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 25, 1957		22c. NAME OF CEMETERY OR CREMATORY Montgomery			
22d. LOCATION (City, town, or county) Clagettville, Md.		24a. REC'D BY REGISTRAR 1-26-57					
24b. REGISTRAR'S SIGNATURE Bernie M. Thompson		24c. REGISTRAR'S ADDRESS Damascus, Md.					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO GENERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race		Date of Death		Place of Death	
John Doe		45		Male		White		Jan 20, 1957		Home	
Cause of Death		Manner of Death		Occupation		Education		Marital Status		Social History	
Heart failure		Natural		Teacher		High School		Married		No	
Time of Death		Place of Death		Signature of Examiner		Signature of Physician		Signature of Coroner		Signature of Witness	
10:30 PM		Home		[Signature]		[Signature]		[Signature]		[Signature]	

Final, second & third degree murder, involving about 60% of body.

was sleeping, when shot and killed.

BUREAU V. S.

JAN 29 1957

RECEIVED

Frank J. Woodbury, M.D.

Jan 25, 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00874

Reg. Dist. No.

211

883

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montg.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Damascus			c. LENGTH OF STAY IN 1b life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Damascus		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) RFD Monrovia				d. STREET ADDRESS RFD Monrovia		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Virgie Irene Moxley				4. DATE OF DEATH Month January Day 22 Year 1957			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 23, 1900		9. AGE (In years last birthday) 56 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Cornelius Moxley				14. MOTHER'S MAIDEN NAME Florence Poole			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 218-24-1440		17. INFORMANT Address Vernie Moxley, Damascus, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH sudden	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Frank J. Broschart				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Frank J. Broschart				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 25, 1957		22c. NAME OF CEMETERY OR CREMATORY Montgomery		22d. LOCATION (City, town, or county) (State) Claggettville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Chas. L. Molesworth				ADDRESS Damascus, Md.		24a. REC'D BY REGISTRAR DATE Jan. 23/57	
				24b. REGISTRAR'S SIGNATURE Wella W. Burdell			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 19
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

JAN 28 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Page and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

884

CERTIFICATE OF DEATH

00875

Reg. Dist. No.

217

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City 03x02	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 73 Montgomery Co. General Hospital, Inc		d. STREET ADDRESS 205 DELLA AVE	
3. NAME OF DECEASED (Type or print) First Ralph Middle Hayward Last Mullineaux		4. DATE OF DEATH Month January Day 25 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/11/91
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Veterinarian		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME HAYWARD MULLINEAUX		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) YES		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) 212-32-0224	
17. INFORMANT Medical Record		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Essential hypertension DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 24 hours 5 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 12/14/56 12:20	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State) Clarksville, Md
21. I certify that I attended the deceased from 12/14/56 , 19 56 , to 12/25/57 , 19 57 , that I last saw the deceased alive on 1/24/57 , 19 57 , and that death occurred at 12:20 M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Charles S. Whitaker		DATE SIGNED 1/25/57	
PHYSICIAN'S NAME (Type) Charles S. Whitaker, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/27/57	22c. NAME OF CEMETERY OR CREMATORY St. Johns Cemetary	22d. LOCATION (City, town, or county) (State) Ellicott City, Md.
23. FUNERAL DIRECTOR'S SIGNATURE PC Hyman		24a. REC'D BY REGISTRAR 28 1957	24b. REGISTRAR'S SIGNATURE Y. Strube-Lawler

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 1 & Item 8, Film G210, 2/4/57 bh
885
CERTIFICATE OF DEATH

00876

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery county</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>			
c. LENGTH OF STAY IN 1b <u>5 years</u>				d. STREET ADDRESS <u>14908 Cushing Drive</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4908 Cushing Drive</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>RUBY</u> First Middle Last <u>GOLDEN NAUGHTON</u>				4. DATE OF DEATH <u>Jan</u> Month <u>27</u> Day <u>1957</u> Year			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan 27 57 1905</u> AGE (In years last birthday) <u>52</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>David Franklin Kogey Rice</u>				14. MOTHER'S MAIDEN NAME <u>Bertha B. Rice</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>John B Naughton</u> Address <u>4908 Cushing Dr -</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>175x Pulmonary edema (terminal)</u> DUE TO (b) <u>Generalized metastatic carcinomatosis</u> DUE TO (c) <u>Carcinoma of left ovary</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u> <u>4 mths</u> <u>7-8 mths</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>May</u> , 1956, to <u>Jan 26</u> , 1957, that I last saw the deceased alive on <u>Jan 26</u> , 1957, and that death occurred at <u>6:15</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>George H. Mc Lain</u> M.D. <u>1746 K St. N.W.</u>				ADDRESS (Street, city or town, state) <u>Washington - D.C.</u> DATE SIGNED <u>Jan 27 - 1957</u>			
PHYSICIAN'S NAME (Type) <u>Geo. H. McLain, M.D.</u>				<u>Washington - D.C.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/31/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Humphrey</u> ADDRESS <u>Bethesda, Md.</u>				24a. REC'D BY REGISTRAR <u>DATE 2-28-57</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

Page One of Two

NAME OF DECEASED GOLDEN BRUNSTON		DATE OF DEATH Jan 27 1957
AGE 57		SEX F
RACE W		EDUCATION HS
BIRTH DATE 1899		PLACE OF BIRTH MD
OCCUPATION Housewife		CAUSE OF DEATH Heart Disease
MANNER OF DEATH Natural		PLACE OF DEATH Home
SIGNATURE OF DECEASED <i>[Signature]</i>		DATE Jan 27 1957
SIGNATURE OF WITNESS <i>[Signature]</i>		DATE Jan 27 1957
SIGNATURE OF PHYSICIAN <i>[Signature]</i>		DATE Jan 27 1957
SIGNATURE OF CORONER <i>[Signature]</i>		DATE Jan 27 1957

BUREAU V. 5

JAN 30 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

886

CERTIFICATE OF DEATH

00877

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 3 yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4407 Maple Avenue				d. STREET ADDRESS 4407 Maple Ave.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First GEORGE Middle W Last NAYLOR				4. DATE OF DEATH Month Jan Day 5 Year 19 57			
5. SEX M		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-19-1872	
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months 8 Days 16		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Railway Postal Clk				10b. KIND OF BUSINESS OR INDUSTRY Ret. Gov.		11. BIRTHPLACE (State or foreign country) Missouri	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME William Naylor				14. MOTHER'S MAIDEN NAME Elizabeth Blanchard			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Sylva Cannon Daughter Dr. Green Acres, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 myocardial failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arterio-sclerosis DUE TO (c) years				INTERVAL BETWEEN ONSET AND DEATH 3 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic lymphoid leukemia				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Bethesda				20g. (County) Montgomery		20h. (State) Maryland	
21. I certify that I attended the deceased from 12-7-1953 to Jan 5, 1957 , that I last saw the deceased alive on Jan 5, 1957 , and that death occurred at 7:30 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Alfred S. Norton				ADDRESS (Street, city or town, state) 4711 Highland Ave Bethesda			
DATE SIGNED 1/5/57							
PHYSICIAN'S NAME (Type) Alfred S. Norton				ADDRESS 4711 Highland Ave. Bethesda, 1/5/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-8-57		22c. NAME OF CEMETERY OR CREMATORY Parklawn		22d. LOCATION (City, town, or county) (State) Montgomery Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumfrey				ADDRESS Bethesda, Md.		24a. REC'D BY REGISTRAR DATE 1-8-57	
24b. REGISTRAR'S SIGNATURE Bessie M. Thompson							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
MAYNARD		21		M		W		1936		BALTIMORE		BALTIMORE		MARYLAND		UNITED STATES	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH	
JAN 10 1957		BALTIMORE		BALTIMORE		MARYLAND		UNITED STATES		JAN 10 1957		BALTIMORE		BALTIMORE		MARYLAND	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		MARRIAGE		SINGLE		MARRIED		DIVORCED	
HEART DISEASE		NATURAL		LABORER		HIGH SCHOOL		METHODIST		MARRIED		MARRIED		MARRIED		MARRIED	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH	
JAN 10 1957		BALTIMORE		BALTIMORE		MARYLAND		UNITED STATES		JAN 10 1957		BALTIMORE		BALTIMORE		MARYLAND	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		MARRIAGE		SINGLE		MARRIED		DIVORCED	
HEART DISEASE		NATURAL		LABORER		HIGH SCHOOL		METHODIST		MARRIED		MARRIED		MARRIED		MARRIED	

BUREAU V. 2

JAN 10 1957

RECEIVED

887

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 14 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 47X-3 Washington c. STREET ADDRESS 1724 27th Street, S.E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Ray Duncan NESTER		4. DATE OF DEATH Month Day Year January 22 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-6-94
9. AGE (In years lost birthday) 62 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Safety Engineer		10b. KIND OF BUSINESS OR INDUSTRY U.S. Government	11. BIRTHPLACE (State or foreign country) Missouri
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Andrew W. Nester	
14. MOTHER'S MAIDEN NAME Ruth Baxter		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes	
16. SOCIAL SECURITY NO. WW-I		17. INFORMANT (Wife) Eleanore G. Nester, (Same As #2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the Lung 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 9 yrs
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 8 Jan. , 19 57 , to 22 Jan , 19 57 , that I last saw the deceased alive on 22 Jan. , 19 57 , and that death occurred at 5:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U.S. Naval Hospital, Bethesda, Md. 1-23-57			
ACTUAL SIGNATURE J.T. Horgan		PHYSICIAN'S NAME (Type) J.T. HORGAN, LT, MC, USN	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 25 Jan. 1957	22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery
22d. LOCATION (City, town, or county) (State) Arlington, Virginia		24a. REC'D BY REGISTRAR 1-23-57	
23. FUNERAL DIRECTOR'S SIGNATURE J.T. Ryan, 317 Penn. Ave., N.W., Washington, D.C.		24b. REGISTRAR'S SIGNATURE Ray E. Carrelly	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 6 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH - BALTIMORE, MD.

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

SEX

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

SEX

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

U.S. GOVERNMENT

U.S. GOVERNMENT

U.S. GOVERNMENT

U.S. GOVERNMENT

U.S. GOVERNMENT

U.S. GOVERNMENT

U.S. GOVERNMENT

U.S. GOVERNMENT

U.S. GOVERNMENT

U.S. GOVERNMENT

BUREAU V. S.

JAN 25 1957

RECEIVED

888

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 159 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		e. STREET ADDRESS 4710 Edgemoor Lane Apt. 101	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Richard Middle Dennis Last NEVILLE		4. DATE OF DEATH Month January Day 18 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4 Sept. 1924
9. AGE (In years last birthday) 32 yrs.		IF UNDER 1 YEAR: Months Days Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy	
11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME James NEVILLE		14. MOTHER'S MAIDEN NAME Viola Balzel	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW-II		16. SOCIAL SECURITY NO. 291-12-4536	
17. INFORMANT (Wife) Fujiko Neville (Same As #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of urinary bladder 181x DUE TO with liver metastases. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) " (c) "		INTERVAL BETWEEN ONSET AND DEATH 4.5 yrs +	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11 Aug. , 19 56 , to 18 January , 19 57 , that I last saw the deceased alive on 17 January , 19 57 , and that death occurred at 2:22 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Byron D. Casteel M.D.		ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 1-18-57	
PHYSICIAN'S NAME (Type) Byron D. Casteel, CAPT, MC, USN		U.S. Naval Hospital, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-23-57	
22c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		22d. LOCATION (City, town, or county) (State) Cleveland, Ohio	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey		24a. REC'D BY REGISTRAR 1-18-57	
ADDRESS 7557 Wisconsin Ave., Bethesda, Md.		24b. REGISTRAR'S SIGNATURE Marie E. Pashley	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Death		Place of Death	
John A. ...		Male		35		January 15, 1957		Baltimore, Md.	
Cause of Death		Occupation		Education		Marital Status		Social Security Number	
U.S. Navy		U.S. Navy		High School		Single		1-23-456789	
Immediate Cause		Underlying Cause		Contributing Cause		Manner of Death		Certified by	
Heart Disease		Heart Disease		Heart Disease		Natural		Dr. ...	
Period of Incubation		Time of Onset		Time of Death		Time of Discovery		Time of Reporting	
24 hours		10:00 AM		11:00 AM		11:00 AM		11:00 AM	
Place of Birth		Place of Residence		Place of Death		Place of Burial		Place of Interment	
Baltimore, Md.		Baltimore, Md.		Baltimore, Md.		Baltimore, Md.		Baltimore, Md.	

BUREAU V. S.

JAN 23 1957

RECEIVED

Name of Physician		Name of Hospital		Name of Clinic		Name of Laboratory		Name of Pharmacy	
Dr. ...		St. ...		St. ...		St. ...		St. ...	
Signature of Physician		Signature of Hospital		Signature of Clinic		Signature of Laboratory		Signature of Pharmacy	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
Date of Signature		Date of Signature		Date of Signature		Date of Signature		Date of Signature	
January 15, 1957		January 15, 1957		January 15, 1957		January 15, 1957		January 15, 1957	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

00880

Reg. Dist. No. 216

889

1. PLACE OF DEATH o. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE New Mexico b. COUNTY Chaves c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Roswell 68x-3 d. STREET ADDRESS 59 Van Lueven Place e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED First Lee Middle Thomas Last Newhouse				4. DATE OF DEATH Month January Day 24th Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 4, 1954		9. AGE (In years lost birthday) yrs. 2	IF UNDER 1 YEAR Months 1 Days 20	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) New Mexico		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Gordon L. Newhouse				14. MOTHER'S MAIDEN NAME Doris Bressette			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 754.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congestive Heart Failure (c) Congenital Heart Disease						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (County) (State)	
21. I certify that I attended the deceased from January 10, 1957 to January 24, 1957 , that I last saw the deceased alive on January 24, 1957 , and that death occurred at 7:50A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Clarence S. Weldon M.D. The Clinical Center 1/24/57 The National Institutes of Health Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/29/1957		22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-7557 Wis. Ave. Bethesda, Md.				24a. REC'D BY REGISTRAR DATE 1-29-57		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

CERTIFICATE OF DEATH

NAME OF DECEASED JAMES H. HARRIS		AGE 65		SEX Male		RACE White	
DATE OF DEATH January 1, 1957		PLACE OF DEATH Home		CITY Baltimore		STATE Maryland	
CAUSE OF DEATH Coronary Thrombosis		MANNER OF DEATH Natural		OCCUPATION Retired		EDUCATION High School	
DATE OF BIRTH January 1, 1892		PLACE OF BIRTH New Mexico		CITY Albuquerque		STATE New Mexico	
FATHER'S NAME JAMES H. HARRIS		MOTHER'S NAME JANE HARRIS		FATHER'S OCCUPATION Farmer		MOTHER'S OCCUPATION Homemaker	
FATHER'S DATE OF BIRTH January 1, 1860		MOTHER'S DATE OF BIRTH January 1, 1865		FATHER'S PLACE OF BIRTH New Mexico		MOTHER'S PLACE OF BIRTH New Mexico	
FATHER'S CITY Albuquerque		MOTHER'S CITY Albuquerque		FATHER'S STATE New Mexico		MOTHER'S STATE New Mexico	
FATHER'S OCCUPATION Farmer		MOTHER'S OCCUPATION Homemaker		FATHER'S EDUCATION High School		MOTHER'S EDUCATION High School	
FATHER'S DATE OF DEATH January 1, 1957		MOTHER'S DATE OF DEATH January 1, 1957		FATHER'S PLACE OF DEATH Home		MOTHER'S PLACE OF DEATH Home	
FATHER'S CITY Albuquerque		MOTHER'S CITY Albuquerque		FATHER'S STATE New Mexico		MOTHER'S STATE New Mexico	
FATHER'S OCCUPATION Farmer		MOTHER'S OCCUPATION Homemaker		FATHER'S EDUCATION High School		MOTHER'S EDUCATION High School	

BUREAU V. S.

JAN 31 1957

RECEIVED

DATE JAN 31 1957		TIME 1:00 PM		PLACE Baltimore		STATE Maryland	
FATHER'S NAME JAMES H. HARRIS		MOTHER'S NAME JANE HARRIS		FATHER'S OCCUPATION Farmer		MOTHER'S OCCUPATION Homemaker	
FATHER'S DATE OF BIRTH January 1, 1860		MOTHER'S DATE OF BIRTH January 1, 1865		FATHER'S PLACE OF BIRTH New Mexico		MOTHER'S PLACE OF BIRTH New Mexico	
FATHER'S CITY Albuquerque		MOTHER'S CITY Albuquerque		FATHER'S STATE New Mexico		MOTHER'S STATE New Mexico	
FATHER'S OCCUPATION Farmer		MOTHER'S OCCUPATION Homemaker		FATHER'S EDUCATION High School		MOTHER'S EDUCATION High School	

1

890 CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>MONTGOMERY</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		LENGTH OF STAY (in this place) <u>2 hrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Suburban Hospital</u>				STREET ADDRESS (If rural give location) <u>12613 Rothern Drive</u>			
3. NAME OF DECEASED (Type or Print) (First) <u>Ralph</u> (Middle) <u>G</u> (Last) <u>Parker</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>1</u> <u>28</u> <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>4/6/97</u>	9. AGE last birthday <u>59</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bookkeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Radio & T.V.</u>		11. BIRTHPLACE (State or foreign country) <u>Canada</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Rupert Fellows Parker</u>				14. MOTHER'S MAIDEN NAME <u>Winifred P. Fisher</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT & ADDRESS <u>Mrs. A. J. Pierson</u> <u>step-daughter - above</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
420.0 IMMEDIATE CAUSE (A) <u>Myocardial infarction</u>						3 hours	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic heart disease</u>						10 year	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Chronic bronchitis</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Post-traumatic epilepsy</u>						35 years	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, lecture, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> A. <input type="checkbox"/>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>November 1953</u> to <u>present</u> 19 <u>57</u> , that I last saw the deceased alive on <u>1-28-57</u> , and that death occurred at <u>1:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Sam Seiger</u>				ADDRESS (Street, city, town, state) <u>931 Pershing Drive Silver Spring, Md.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Transit-Burial</u>		DATE THEREOF <u>1/31/57</u>		NAME OF CEMETERY OR CREMATORY <u>Cheshire Cemetery</u>		LOCATION (City, town, or county) (State) <u>Cheshire, Massachusetts</u>	
24. REC'D BY REGISTRAR <u>1-30-57</u>		REGISTRAR'S SIGNATURE <u>Bennie H. Thompson</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey</u>		ADDRESS <u>Silver Spring, Md.</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The original copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

RECEIVED

891

CERTIFICATE OF DEATH

Reg. Dist. No.

214

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town). <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>820 Bonifant Street</u>		d. STREET ADDRESS <u>1 820 Bonifant Street</u>	
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>EMERSON</u> Last <u>PERRY SR.</u>		4. DATE OF DEATH Month <u>JANUARY</u> Day <u>14</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 29, 1887</u>
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>9</u> Hours <u>14</u> Min. <u>19</u>	IF UNDER 24 HRS. Hours <u>14</u> Min. <u>19</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lawyer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Law</u>	
11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>JAMES PERRY</u>		14. MOTHER'S MAIDEN NAME <u>ANNIE NORMAN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>MRS. MARY DICKSON</u>		Address <u>7206 CROSBY ROAD SILVER SPRING, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular fibrillation</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary occlusion</u> (c) <u>Coronary atherosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Seconds.</u> <u>15 minutes.</u> <u>5 years.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Previous Myocardial Infarction August 1953</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>August, 1953</u> , to <u>January 14, 1957</u> , that I last saw the deceased alive on <u>January 8, 1957</u> , and that death occurred at <u>8:00 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James A. Roberts</u>		ADDRESS (Street, city or town, state) <u>5907 GEORGIA AVE SILVER SPRING, MD.</u>	
PHYSICIAN'S NAME (Type) <u>JAMES A. ROBERTS M.D.</u>		DATE SIGNED <u>JAN. 14 1957</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1/17/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>PRINCE GEORGE COUNTY, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter E. Humphrey</u>		24a. REC'D BY REGISTRAR <u>4/17/57</u>	
ADDRESS <u>SILVER SPRING, MD.</u>		24b. REGISTRAR'S SIGNATURE <u>Sharon Datter</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove coronian papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V.

JAN 21 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

892

CERTIFICATE OF DEATH

00883

Reg. Dist. No. 216

1. PLACE OF DEATH- COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <i>Maryland</i> COUNTY <i>Montgomery</i>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <i>Bethesda</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>	
TOWN <i>Bethesda</i>		TOWN <i>Bethesda</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>9305 Parkhill Terrace</i>		STREET ADDRESS <i>9305 Parkhill Terrace</i>	
3. NAME OF DECEASED (Type or Print) <i>Olivia</i> (First) <i>Vermon</i> (Middle) <i>Pitcher</i> (Last)		4. DATE OF DEATH (Month) <i>Jan.</i> (Day) <i>22</i> (Year) <i>1957</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Unmarried</i>	8. DATE OF BIRTH <i>June 25, 1901</i>
9. AGE last birthday <i>75</i> yrs.		10. BIRTHPLACE (State or foreign country) <i>Virginia</i>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Benjamin F. Coppage</i>		14. MOTHER'S MAIDEN NAME <i>Caroline Ellen Smith</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If year, give war or dates of service)		16. SOCIAL SECURITY No. <i>Unknown</i>	
17. INFORMANT AND ADDRESS <i>George R. Kettering-See item 2</i>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
4-20-1 Immediate cause (a) <i>Coronary Heart failure</i>		<i>4 years</i>	
Antecedent cause(s) (b) <i>Coronary arteriosclerotic heart disease</i>		<i>6 years</i>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT (Specify) <i>SUICIDE</i>		PLACE (Home, farm, factory, street, OF office bldg., etc.)	
HOMICIDE		INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>Jan.</i> , 19 <i>57</i> , to <i>1-22</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>1-22</i> , 19 <i>57</i> , and that death occurred at <i>6:30 A.M.</i> , from the causes and on the date stated above.			
SIGNATURE <i>John R. Kettering</i> (Degree or title)		ADDRESS <i>901-20th Ave. Wash. D.C.</i> DATE SIGNED <i>1-22-57</i>	
23. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		DATE <i>1/25/57</i>	
NAME OF CEMETERY OR CREMATORY <i>Fairview</i>		LOCATION (City, town, or county) <i>Culpepper</i> (State) <i>Virginia</i>	
DATE REC'D BY LOCAL REG <i>1-23-57</i>		REGISTRAR'S SIGNATURE <i>George M. Thompson</i>	
24. FUNERAL DIRECTOR <i>Robert A. Pumphrey</i>		ADDRESS <i>Bethesda, Md.</i>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 28 1957

BUREAU V. S.

783

CERTIFICATE OF DEATH

Reg. Dist. No.

00884
773

1. PLACE OF DEATH a. COUNTY <u>Montgomery County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>P. 600</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park 12, D.C.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>College Park 16-14-2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium and Hospital</u>				d. STREET ADDRESS <u>3120 Powder Mill Road</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Mr. John William Quackenbush</u>		4. DATE OF DEATH <u>January 24 1957</u>		Month <u>January</u> Day <u>24</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>cauc.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/19/70</u>	9. AGE (In years last birthday) <u>86</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>Amer.</u>	
13. FATHER'S NAME <u>Mr. John Quackenbush</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Rose</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>son</u>		17. INFORMANT <u>Russell Quackenbush</u> Address <u>7404 Aspen Ave., Takoma Pk. Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerosis generalized</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>90 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Paralysis agitans</u> (b) <u>Cystitis</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>July 1, 1952</u> , to <u>Jan. 24, 1957</u> , that I last saw the deceased alive on <u>Jan. 24, 1957</u> , and that death occurred at <u>3:45 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James M. [Signature]</u> M.D.		ADDRESS (Street, city or town, state) <u>7701 Carroll Ave</u> DATE SIGNED <u>1-24-57</u>					
PHYSICIAN'S NAME (Type) <u>Takoma Park, 12, Md</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 27, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>George Washington Cemetery</u>		22d. LOCATION (City, town, or county) <u>Prince George Co Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters, 254 Carroll St NW DC</u>				24a. REC'D BY REGISTRAR <u>Jan 28 1957</u>		24b. REGISTRAR'S SIGNATURE <u>J. Wilson Dadds</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Page 1 of 1

1. Name of deceased		2. Sex		3. Age		4. Date of birth		5. Place of birth		6. Date of death		7. Place of death		8. Cause of death		9. Manner of death		10. Signature of physician		11. Signature of registrar		12. Date of registration	
JAMES EARL RAY		Male		35		1922		Missouri		April 4, 1968		Memphis, Tennessee		Shot		Suicide		[Signature]		[Signature]		April 4, 1968	
13. Name of informant		14. Relationship		15. Address		16. City		17. State		18. Zip		19. Telephone		20. Signature of informant		21. Date of completion		22. Signature of registrar		23. Date of registration		24. Signature of registrar	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. S.

JAN 28 1967

RECEIVED

Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00885

893

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New York b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Maryland		c. LENGTH OF STAY IN 1b 5 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Orient, Long Island 69X-3		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.			d. STREET ADDRESS Navy Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Frederick Middle Irving Last Rackett			4. DATE OF DEATH Month January Day 8 Year 1957		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 18, 1942		9. AGE (In years last birthday) 14 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) New York	
13. FATHER'S NAME Frederick F. Rackett			14. MOTHER'S MAIDEN NAME Harriet Rogers		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 204.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute lymphocytic leukemia DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Gastrointestinal bleeding					INTERVAL BETWEEN ONSET AND DEATH 60+ hrs 1 1/2 mos
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from January 3 , 19 57 , to January 8 , 19 57 , that I last saw the deceased alive on January 8 , 19 57 , and that death occurred at 10:40 PM , from the causes and on the date stated above.					
ACTUAL SIGNATURE Samuel Charache		M.D. The Clinical Center		ADDRESS (Street, city or town, state) National Institutes of Health	
PHYSICIAN'S NAME (Type) Samuel Charache, M.D.		Bethesda 14, Maryland		DATE SIGNED 1/9/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Transit		22b. DATE THEREOF 1/9/57		22c. NAME OF CEMETERY OR CREMATORY Central Cemetery	
22d. LOCATION (City, town, or county) Long Island, New York		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.			ADDRESS		24a. REC'D BY REGISTRAR DATE 1-10-57
			24b. REGISTRAR'S SIGNATURE Bessie M. Thompson		

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
JAMES J. HENRY		45		M		W		JAN 15 1892		NEW YORK		NEW YORK		NEW YORK	
MARRIAGE		DATE		PLACE		CITY		COUNTRY		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
MARRIED		JAN 15 1915		NEW YORK		NEW YORK		NEW YORK		JAN 15 1957		NEW YORK		NEW YORK	
OCCUPATION		DATE		PLACE		CITY		COUNTRY		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
LABORER		JAN 15 1957		NEW YORK		NEW YORK		NEW YORK		JAN 15 1957		NEW YORK		NEW YORK	
CAUSE OF DEATH		DATE		PLACE		CITY		COUNTRY		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
HEART DISEASE		JAN 15 1957		NEW YORK		NEW YORK		NEW YORK		JAN 15 1957		NEW YORK		NEW YORK	
MANNER OF DEATH		DATE		PLACE		CITY		COUNTRY		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
NATURAL		JAN 15 1957		NEW YORK		NEW YORK		NEW YORK		JAN 15 1957		NEW YORK		NEW YORK	
SIGNATURE OF PHYSICIAN		DATE		PLACE		CITY		COUNTRY		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
JAMES J. HENRY		JAN 15 1957		NEW YORK		NEW YORK		NEW YORK		JAN 15 1957		NEW YORK		NEW YORK	
SIGNATURE OF REGISTRAR		DATE		PLACE		CITY		COUNTRY		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
JAMES J. HENRY		JAN 15 1957		NEW YORK		NEW YORK		NEW YORK		JAN 15 1957		NEW YORK		NEW YORK	

BUREAU V. S.

JAN 15 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

894

CERTIFICATE OF DEATH

00886

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>New Jersey</u> b. COUNTY <u>Orange</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda 14, Maryland</u>				c. LENGTH OF STAY IN 1b <u>11 days</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Orange 67X-3</u>				d. STREET ADDRESS <u>339 Mechanic Street</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>--</u> Last <u>Rella</u>				4. DATE OF DEATH Month <u>January</u> Day <u>24</u> Year <u>19 57</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 9, 1955</u>	
9. AGE (In years last birthday) <u>1</u> yrs.		IF UNDER 1 YEAR Months <u>5</u> Days <u>15</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Minor Child</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>- - - - -</u>			
11. BIRTHPLACE (State or foreign country) <u>New Jersey</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>Stephan Rella</u>				14. MOTHER'S MAIDEN NAME <u>Angelina Cuccinello</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> <u>754.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CONGENITAL HEART DISEASE, Ventricular Septal Defect</u> DUE TO (c) <u>Heart Surgery - Post Op</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs</u> <u>6 Hr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>a. m.</u> <u>19</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u></u>				(County) <u></u>		(State) <u></u>	
21. I certify that I attended the deceased from <u>January 13</u> , 19 <u>57</u> , to <u>January 24</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>January 24</u> , 19 <u>57</u> , and that death occurred at <u>6:13 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Theodore Cooper</u>				ADDRESS (Street, city or town, state) <u>The Clinical Center</u>			
PHYSICIAN'S NAME (Type) <u>Theodore Cooper, M. D.</u>				DATE SIGNED <u>1/25/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-transit</u>		22b. DATE THEREOF <u>1/25/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>		22d. LOCATION (City, town, or county) (State) <u>Morris Co. New Jersey</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-7557 Wis. Ave. Beth. Md.</u>				24a. REC'D BY REGISTRAR DATE <u>1-28-57</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH - BALTIMORE, MD.

FILE NO.

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

SEX

EDUCATION

RELIGION

OCCUPATION

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

BUREAU V. S.

JAN 30 1957

RECEIVED

895

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE District of Columbia COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 6 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Maryland				d. STREET ADDRESS 1715 Minnesota Ave., S.E.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Frederick Middle August Last REMUS		4. DATE OF DEATH Month January Day 13 Year 1957					
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-29-1895	9. AGE (In years last birthday) yrs. 61	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Railroad Conductor		10b. KIND OF BUSINESS OR INDUSTRY Civil Service		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Karl Remus				14. MOTHER'S MAIDEN NAME Bertha DOLLAS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) World War 1		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT (wife) Mildred Remus (Same as #2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-7- 1957 , to 1-13- 1957 , that I last saw the deceased alive on 1-12- 1957 , and that death occurred at 0423 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE William C.E. Pfischner M.D. U.S. Naval Hospital, Bethesda, Md. 1-13-57 PHYSICIAN'S NAME (Type) William C.E. PFISCHNER, LCDR MC U.S. Naval Hospital, Bethesda, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried		22b. DATE THEREOF 1-16-57		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Simmons Bros. ADDRESS 1661 Good Hope Rd, Washington DC				24a. REC'D BY REGISTRAR Mary E. Parrelly		24b. REGISTRAR'S SIGNATURE Mary E. Parrelly	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

<p>NAME (Last, first, middle) JAMES EARL RAY</p>		<p>DATE OF BIRTH 10-14-1928</p>		<p>PLACE OF BIRTH MOBILE, ALABAMA</p>	
<p>DATE OF DEATH 4-4-68</p>		<p>PLACE OF DEATH MEMPHIS, TENNESSEE</p>		<p>CAUSE OF DEATH (To be filled in by physician)</p>	
<p>DATE OF BURIAL 4-8-68</p>		<p>PLACE OF BURIAL GREENWICH CEMETERY, GREENWICH, CT</p>		<p>NAME OF FUNERAL HOME (To be filled in by funeral home)</p>	
<p>DATE OF ISSUANCE 4-10-68</p>		<p>PLACE OF ISSUANCE BALTIMORE, MD</p>		<p>NAME OF PHYSICIAN (To be filled in by physician)</p>	
<p>DATE OF REGISTRATION 4-10-68</p>		<p>PLACE OF REGISTRATION BALTIMORE, MD</p>		<p>NAME OF REGISTRAR (To be filled in by registrar)</p>	
<p>DATE OF RECEIPT 4-10-68</p>		<p>PLACE OF RECEIPT BALTIMORE, MD</p>		<p>NAME OF RECIPIENT (To be filled in by recipient)</p>	

BUREAU V. 2

JAN 16 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00888

896

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>56 Silver Spring</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>204 Indian Spring Drive</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Marie Gertrude Robbins</i>				4. DATE OF DEATH Month <i>January</i> Day <i>9</i> Year <i>1957</i>			
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12/8/20</i>		9. AGE (In years lost birthday) <i>36</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Araconda, Montana</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Charles Forrester</i>				14. MOTHER'S MAIDEN NAME <i>Marie T. Greene</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>547-22-3091</i>		17. INFORMANT <i>William Warren Robbins</i> Address <i>204 Indian Spring Dr. S.S. Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary embolus</i> <i>570.5</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Chronic obstruction of intestines</i> DUE TO (c) <i>Mass in abdomen</i>						INTERVAL BETWEEN ONSET AND DEATH <i>half hour</i> <i>2 years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <i>Oct 1954</i> to <i>Oct 1956</i> , that I last saw the deceased alive on <i>Oct 1956</i> , and that death occurred at <i>7:40</i> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>John N. Andrews</i>				ADDRESS (Street, city or town, state) <i>960 Coleville Rd Silver Spring, Md</i>		DATE SIGNED <i>1-9-57</i>	
PHYSICIAN'S NAME (Type) <i>John N. Andrews</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>		22b. DATE THEREOF <i>1/11/57</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Ft. Lincoln Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Prince Georges County, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>The S.H. Hines Co. Washington, D.C.</i>				24a. REC'D BY REGISTRAR <i>1/10/57</i>		24b. REGISTRAR'S SIGNATURE <i>Frances Toller</i>	

BUREAU V. S.

JAN 14 1957

RECEIVED

897

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Woodstock	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodstock 838-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		d. STREET ADDRESS Spring STREET	
3. NAME OF DECEASED (Type or print) NANNIE First Rodeffer Middle Rodeffer		4. DATE OF DEATH January 16 1956 Month January Day 16 Year 1956	
5. SEX 7	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/14/76
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) Virginia	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME JAMES		14. MOTHER'S MAIDEN NAME MORRIS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. —	17. INFORMANT Edna Harlow Address 3623 Glenmont Drive Ch. 26 Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Embolism 433.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Auricular Fibrillation DUE TO (c) —			INTERVAL BETWEEN ONSET AND DEATH 15 hrs. 2.5 hrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Congestive Heart Failure			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) NONE	
20c. TIME OF INJURY Month, Day, Year Hour a. p. NONE 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 2/15 , 19 56 , to 1/16 , 19 56 that I last saw the deceased alive on 1/16 , 19 57 , and that death occurred at 740 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE John B. Umhau M.D.		ADDRESS (Street, city or town, state) 8805 Penn. Ave DATE SIGNED 1/16/57	
PHYSICIAN'S NAME (Type) John B. Umhau		 Chevy Chase 15 Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) removal	22b. DATE THEREOF 1/17/57	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State) Woodstock, Va.
23. FUNERAL DIRECTOR'S SIGNATURE S.H. Harris Co ADDRESS 2901-14 St. N.W. Wash. DC.		24a. REC'D BY REGISTRAR DATE-18-57	24b. REGISTRAR'S SIGNATURE Bennie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

PLACE TO BE FILLED BY THE REGISTRAR	
NAME OF DECEASED	
AGE	
SEX	
RACE	
DATE OF DEATH	
PLACE OF DEATH	
CAUSE OF DEATH	
MANNER OF DEATH	
SIGNATURE OF REGISTRAR	
DATE	

BUREAU V. 3

JAN 21 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00890
Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>D.O.A.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Roosevelt St. + Old Georgetown Rd</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>478-3</u> d. STREET ADDRESS <u>1401 Yerkinium St NW</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Warren Alfred Ross</u> First Middle Last		4. DATE OF DEATH Month <u>Jan</u> Day <u>30</u> Year <u>1957</u>		5. SEX <u>male</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>March 2, 1870</u> 9. AGE (In years last birthday) <u>86</u> yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - OWNER</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Elect Supply</u> 11. BIRTHPLACE (State or foreign country) <u>Pa</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.C</u>		13. FATHER'S NAME <u>Alfred Ross</u> 14. MOTHER'S MAIDEN NAME <u>Lavinia Carl</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> 16. SOCIAL SECURITY NO. <u>yes</u> 17. INFORMANT <u>Geo Martin</u> Address <u>5306 Hampton Hwy Bethesda Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>sudden</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschek</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>1-30-57</u>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschek</u>		22a. BURIAL, CREMATION, REMOVAL (Specify) <u>ENTOMBMENT</u> 22b. DATE THEREOF <u>2/1/57</u> 22c. NAME OF CEMETERY OR CREMATORY <u>HT. LINCOLN CEMETERY</u> 22d. LOCATION (City, town, or county) <u>PRINCE GEORGE COUNTY, MD.</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey</u> ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR <u>DATE 1-1-57</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 3

FEB 4 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 899
 CERTIFICATE OF DEATH

00891
 276

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Maryland				c. LENGTH OF STAY IN 1b 65 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 26 Rockville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 13106 Parkland Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Jean Middle Louise Last Sansbury				4. DATE OF DEATH Month January Day 9 Year 19 57			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 5, 1925		9. AGE (In years last birthday) 31 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dance Instructor		10b. KIND OF BUSINESS OR INDUSTRY Instructor of Dancing		11. BIRTHPLACE (State or foreign country) District of Columbia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Richard Riggle				14. MOTHER'S MAIDEN NAME Stella Newick			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. unknown		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute leukemia 204.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) chronic regenerative anemia etc DUE TO (c) paroxysmal INTERVAL BETWEEN ONSET AND DEATH 7 mos. 5 days.						PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November 5, 19 56 to January 9, 19 57 , that I last saw the deceased alive on January 9, 19 57 , and that death occurred at 1:40 P. M, from the causes and on the date stated above.							
ACTUAL SIGNATURE D. G. Nathan, M.D.				ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 1/9/57			
PHYSICIAN'S NAME (Type) D. G. NATHAN, M. D.				ADDRESS National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 1/12/57		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.		22d. LOCATION (City, town, or county) (State) Suitland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE A. H. Kane Co., Washington, D.C.				24. REC'D BY REGISTRAR JAN 11 1957			
ADDRESS Washington, D.C.				24b. REGISTRAR'S SIGNATURE Beattie Thompson			

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON, MASS.
CERTIFICATE OF DEATH

NAME OF DECEASED JAMES J. JONES		SEX Male		AGE 32 years	
PLACE OF BIRTH New York, N.Y.		DATE OF BIRTH January 1, 1925		PLACE OF DEATH Boston, Mass.	
OCCUPATION Clerk		CAUSE OF DEATH Myocardial Infarction		MANNER OF DEATH Natural	
DATE OF DEATH January 11, 1957		TIME OF DEATH 10:30 A.M.		PLACE OF INTERMENT St. John's Cemetery, Boston	
SIGNATURE OF PHYSICIAN [Signature]		SIGNATURE OF REGISTRAR [Signature]		SIGNATURE OF CLERK [Signature]	

BUREAU V. S.

JAN 11 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00892

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 214

900

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN TB 16 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 SILVER SPRING			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 9708 LAWNDALDE DRIVE				d. STREET ADDRESS 1 9708 LAWNDALDE DRIVE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOHN First B. Middle SCHOONMAKER Last				4. DATE OF DEATH JANUARY 12 Month 19 57 Year			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 14, 1908		9. AGE (In years last birthday) 48 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ACCOUNTANT		10b. KIND OF BUSINESS OR INDUSTRY C. & P. TELEPHONE CO.		11. BIRTHPLACE (State or foreign country) D. of C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME WARREN M. SCHOONMAKER				14. MOTHER'S MAIDEN NAME DAISY V. ROTHWELL			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 577-01-0862		17. INFORMANT Address Mrs. Mary E. Schoonmaker, 9708 Lawndalde Drive, Silver Spring, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ASPHYXIA DUE TO HANGING 974x DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH SUICIDE							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) FOUND HANGING FROM BEAM IN BASEMENT OF HOME					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 10:00 A. p. m. 1/12/57		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Frank J. Broschart				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) FRANK J. BROSCHART				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1/15/57		22c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY		22d. LOCATION (City, town, or county) (State) PRINCE GEORGE COUNTY, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey				ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE 1/12/57	
				24b. REGISTRAR'S SIGNATURE Frances Potter			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF EXAMINER		DATE	
EDUCATION		MARRIAGE		DISEASE		INJURY		TESTIMONY		FINDINGS	
RELIGION		SOCIETY		SYMPTOMS		TREATMENT		HISTORY		OPINION	
FAMILY HISTORY		PREVIOUS ILLNESS		LABORATORY TESTS		X-RAY		PATHOLOGICAL FINDINGS		FINAL DIAGNOSIS	
VITALS		TEMPERATURE		PULSE		BLOOD PRESSURE		RESPIRATION		WEIGHT	
HEART		LUNGS		LIVER		SPLEEN		PANCREAS		INTESTINES	
KIDNEYS		BLADDER		PROSTATE		UTERUS		VAGINA		TESTES	
SKIN		EYES		EARS		NOSE		MOUTH		THROAT	
NECK		CHEST		ABDOMEN		PELVIS		EXTREMITIES		GENERAL APPEARANCE	
MENTAL STATE		MORAL STATE		SOCIAL STATE		FAMILY STATE		COMMUNITY STATE		NATIONAL STATE	
RELIGIOUS STATE		POLITICAL STATE		ECONOMIC STATE		CULTURAL STATE		SCIENTIFIC STATE		ARTISTIC STATE	
LITERARY STATE		MUSICAL STATE		THEATRICAL STATE		SPORTS STATE		GAMING STATE		DANCE STATE	
FASHION STATE		FOOD STATE		DRINK STATE		SMOKE STATE		TOBACCO STATE		GAMING STATE	
RELIGIOUS STATE		POLITICAL STATE		ECONOMIC STATE		CULTURAL STATE		SCIENTIFIC STATE		ARTISTIC STATE	
LITERARY STATE		MUSICAL STATE		THEATRICAL STATE		SPORTS STATE		GAMING STATE		DANCE STATE	
FASHION STATE		FOOD STATE		DRINK STATE		SMOKE STATE		TOBACCO STATE		GAMING STATE	

BUREAU V. S.

JAN 21 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

em 18 Film 210 2-4-57 ams

901

CERTIFICATE OF DEATH

00893

Reg. Dist. No. 216

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 84 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury 22-12-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center				d. STREET ADDRESS North Salisbury Boulevard		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Marguerite Middle Taylor Last Senter				4. DATE OF DEATH Month January Day 23rd , Year 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 23, 1910	
9. AGE (In years last birthday) 46 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10b. KIND OF BUSINESS OR INDUSTRY Public School		11. BIRTHPLACE (State or foreign country) Michigan	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Cary G. Taylor		14. MOTHER'S MAIDEN NAME Mary Ellen Newlin			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Not available		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 725x interstitial pneumonia, underlying DUE TO etiology Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) cause undetermined at present time DUE TO (c) Arthritis, anemia, hyperglobulinemia, fever							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. 19				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Oct. 31st, 19 56 to Jan. 23rd, 19 57 , that I last saw the deceased alive on Jan. 23rd, 19 57 , and that death occurred at 1225 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 1/23/57 ACTUAL SIGNATURE James L. German, M.D. The National Institutes of Health Bethesda 14, Maryland PHYSICIAN'S NAME (Type) James L. German, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Trans. & Burial		1/26/57		New London, Indiana			
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Pumphrey, Silver Spring				ADDRESS 1-26-57		24a. REC'D BY REGISTRAR Bessie M. Thompson	
				24b. REGISTRAR'S SIGNATURE			

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

Section 1

1957

MASSACHUSETTS

1957

1957

1957

1957

1957

1957

1957

1957

1957

1957

1957

1957

1957

1957

1957

1957

1957

1957

1957

1957

1957

1957

1957

1957

1957

1957

1957

1957

1957

1957

1957

1957

BUREAU V. S.

JAN 29 1957

RECEIVED

902 CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>			c. LENGTH OF STAY IN 1b <u>4 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>47X-3 Washington</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Bethesda, Md.</u>				d. STREET ADDRESS <u>17 Forrester, St., S.W.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Carolyn Ann SINCLAIR</u>				4. DATE OF DEATH Month Day Year <u>January 24 19 57</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9 January 1957</u>		9. AGE (In years lost birthday) yrs. Months Days Hours Min. <u>15</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Thomas Sinclair</u>				14. MOTHER'S MAIDEN NAME <u>Ruby Wallace</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Father, Thomas Sinclair (Same As #2)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Dehydration and hyoelectrolytemia</u> <u>764.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Gastroenteritis, acute</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>5 1/2 Days</u> <u>5 1/2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Subarachnoid hemorrhage, frontal hemispheres, bilateral, slight.</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. ft. p. m. Month, Day, Year <u>19</u>			20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>20 January</u> , 19 <u>57</u> to <u>24 January</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>24 January</u> , 19 <u>57</u> , and that death occurred at <u>6:40 P. M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Charles Waite</u>			M.D. <u>U.S. Naval Hospital, Bethesda, Md. 1-25-57</u>				
PHYSICIAN'S NAME (Type) <u>Charles Waite, CDR, MC, USN</u>			<u>U.S. Naval Hospital, Bethesda, Md.</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-29-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Chambers, 517 11th St., S.E. Washington, D.C.</u>				24a. REC'D BY REGISTRAR <u>DATE 1-25-57</u>		24b. REGISTRAR'S SIGNATURE <u>May B. Parrelly</u>	

MD. KAYLARD STATE DEPARTMENT OF HEALTH - BALTIMORE, 10

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Dist. of Columbia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 307 - 11th Street, S. E.	
3. NAME OF DECEASED First Carrie Middle (none) Last Smith		4. DATE OF DEATH Month January Day 29 Year 19 57	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 19, 1905
9. AGE (In years last birthday) 51 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME James James		14. MOTHER'S MAIDEN NAME Maria Brooks	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MACNUTRITION 171X DUE TO SEVERE RADIATION ENTERITIS EXTENSIVE ADHESIONS & ILEOCECTANEOUS ATITULA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CARCINOMA OF UTERINE CERVIX (c) 1 YR.			INTERVAL BETWEEN ONSET AND DEATH 1 MONTH 7 MOS 4 DAYS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) HYPERTENSIVE ARTERIOVASCULAR DISEASE, UREMIA			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. p. m. _____ Month, Day, Year 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November 18, 1956 , to January 29, 1957 , that I last saw the deceased alive on January 29, 1957 , and that death occurred at 6:50 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Gurston Goldin		ADDRESS (Street, city or town, state) DATE SIGNED The Clinical Center 1/30/57 National Institutes of Health Bethesda 14, Maryland	
PHYSICIAN'S NAME (Type) Gurston Goldin, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Feb-2-1957	22c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cemetery	22d. LOCATION (City, town, or county) (State) Caroline County, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE John T. Rhines & Co.,		ADDRESS 901 3rd St., S. W.	
24a. REC'D BY REGISTRAR EB 1		24b. REGISTRAR'S SIGNATURE Bessie Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
JAMES H. HARRIS		45		M		W		1871		BALTIMORE		MD		U.S.A.	
MARRIAGE		DATE		PLACE		CITY		COUNTRY		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
MARRIED		1895		BALTIMORE		MD		U.S.A.		FEB 1 1937		BALTIMORE		MD	
CAUSE OF DEATH		DISEASE		COMPLICATIONS		TREATMENT		HISTORY		SIGNATURE OF PHYSICIAN		DATE		PLACE	
HEART DISEASE		CORONARY ARTERY DISEASE		HYPERTENSION		MEDICINE		NONE		J. H. HARRIS		FEB 1 1937		BALTIMORE	
MANNER OF DEATH		NATURAL		ACCIDENT		SUICIDE		OTHER		SIGNATURE OF CORONER		DATE		PLACE	
NATURAL		NONE		NONE		NONE		NONE		J. H. HARRIS		FEB 1 1937		BALTIMORE	
PLACE OF INTERMENT		CITY		COUNTRY		DATE		PLACE		SIGNATURE OF MINISTER		DATE		PLACE	
BALTIMORE		MD		U.S.A.		FEB 1 1937		BALTIMORE		J. H. HARRIS		FEB 1 1937		BALTIMORE	

BUREAU V. S.

FEB 1 1937

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 11 Film G210 1-29-57 et

CERTIFICATE OF DEATH

00896

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Olney</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X 2 Gaithersburg</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Montgomery County General</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>William</i> Middle <i>Edward</i> Last <i>Sommerville Jr</i>		4. DATE OF DEATH Month <i>Jan</i> Day <i>17</i> Year <i>1950</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov. 1, 1950</i>
9. AGE (In years last birthday) <i>6</i> yrs.		IF UNDER 1 YEAR Months <i>6</i> Days <i>6</i>	IF UNDER 24 HRS. Hours <i>6</i> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <i>Montgomery Co., Md.</i>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>William Edward Sommerville Sr.</i>		14. MOTHER'S MAIDEN NAME <i>Catherine Bruchant</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Wm E. Sommerville. Gaithersburg, Md.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Dehydration</i> <i>580x</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <i>Acute hepatitis</i> DUE TO (c) <i>5 days</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <i>48 hrs</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>JAN 16</i> , 19 <i>50</i> , to <i>JAN 17</i> , 19 <i>50</i> , that I last saw the deceased alive on <i>JAN 12</i> , 19 <i>50</i> , and that death occurred at <i>1:10 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>A. D. Bonifant</i>		ADDRESS (Street, city or town, state) DATE SIGNED <i>1/19/50</i>	
PHYSICIAN'S NAME (Type) <i>A. D. BONIFANT</i>		M.D. <i>Sandy Spring, Md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>1-19-57</i>	22c. NAME OF CEMETERY OR CREMATORY <i>St Rose,</i>	22d. LOCATION (City, town, or county) (State) <i>Glopper. Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Ernest C. Gartner</i>		ADDRESS <i>Gaithersburg Md.</i>	
24a. REC'D BY REGISTRAR <i>DATE 1-19-57</i>		24b. REGISTRAR'S SIGNATURE <i>Katherine B. Lawler</i>	

73

1

1

134

BUREAU V. S.

JAN 23 1957

RECEIVED

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

00897

Reg. Dist. No. 216

905

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 5 weeks			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hosp.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
4. DATE OF DEATH January 6 19 57				5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 1866 September 29, 9. AGE (In years last birthday) 90 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk, U.S.Gov.				10b. KIND OF BUSINESS OR INDUSTRY Retired			
11. BIRTHPLACE (State or foreign country) Vermont				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME E. Sornborger				14. MOTHER'S MAIDEN NAME Hannah Barber			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) ----				16. SOCIAL SECURITY NO. no			
17. INFORMANT Daughter, Dorothy G. Sornborger, same as #2				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho-pneumonia, hypostatic 2° to Ant. Heart D. decompensated 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Congestive H.F.: Bilateral Pleural effusion + Pericardial effusion DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 904.9 Fractured Rt Femur + Hip wiring				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Dec 1, 1956 , to JAN 6, 1957 , that I last saw the deceased alive on JAN 5, 1957 , and that death occurred at 4:35 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Austin B. Rohrbaugh M.D.				ADDRESS (Street, city or town, state) 104 Cherry Chase Dr. DATE SIGNED 1/6/57			
PHYSICIAN'S NAME (Type) Austin B. Rohrbaugh				104 Cherry Chase Dr.			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 1/8/57		22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE She S. H. Hines Co ADDRESS 2901-14th St. N.W.				24a. REC'D BY REGISTRAR 1-8-57		24b. REGISTRAR'S SIGNATURE Beanie M. Thompson	

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

906

CERTIFICATE OF DEATH

00898

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 Kensington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		d. STREET ADDRESS <u>14401 EVERETT STREET</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>HOLMAN CRAW SPARKS</u>		4. DATE OF DEATH Month Day Year <u>1 - 8 1957</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-22-80</u>
9. AGE (In years last birthday) <u>46</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Used CAR MANAGER - RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Kentucky</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John Sparks</u>		14. MOTHER'S MAIDEN NAME <u>MARGARET</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>577-05-8208</u>	
17. INFORMANT (Name) <u>Mabelle Sparks</u>		Address <u>Kensington, Md.</u> <u>4401 Everett St.</u>	
18. CAUSE OF DEATH [Enter only one cause pending for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Coronary Heart Disease</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260X Diabetes Mellitus mild.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1/7</u> , 19 <u>57</u> , to <u>1/8</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1/8</u> , 19 <u>57</u> , and that death occurred at <u>10:15</u> AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Dean H. Harding</u> M.D.		ADDRESS (Street, city or town, state) <u>113 Carroll St NW, Wash DC</u> DATE SIGNED <u>1/8/57</u>	
PHYSICIAN'S NAME (Type) <u>Dean H. Harding</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>1/10/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Maple Grove Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Nicholasville, Kentucky</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A H Hines Co.</u>		ADDRESS <u>2901 14th NW</u>	
24a. REC'D BY REGISTRAR <u>DATE 11 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie Thompson</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John J. Smith</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>Jan 10 1957</i>		5. TIME OF DEATH <i>10:30 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Myocardial Infarction</i>		8. MANNER OF DEATH <i>Natural</i>		9. PLACE OF BIRTH <i>Baltimore, Md.</i>	
10. OCCUPATION <i>Engineer</i>		11. MARITAL STATUS <i>Married</i>		12. EDUCATION <i>High School</i>	
13. PREVIOUS ILLNESS <i>None</i>		14. MEDICAL HISTORY <i>None</i>		15. SIGNATURE OF PHYSICIAN <i>John J. Smith</i>	
16. SIGNATURE OF WITNESS <i>John J. Smith</i>		17. SIGNATURE OF DECEASED <i>John J. Smith</i>		18. SIGNATURE OF REGISTRAR <i>John J. Smith</i>	

BUREAU V. 2

JAN 11 1957

RECEIVED

907

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase		c. LENGTH OF STAY IN 1b 4 1/4 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7002 Brookville Road		d. STREET ADDRESS 7002 Brookville Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Walter Middle STEVENS Last STEVENS		4. DATE OF DEATH Month January Day 28 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 24, 1875
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months 11 Days 4 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Watchman		10b. KIND OF BUSINESS OR INDUSTRY Retired ???	
11. BIRTHPLACE (State or foreign country) Camden Co. N. Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph Stevens		14. MOTHER'S MAIDEN NAME Emma Jane Morris	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 228-18-7540A	
17. INFORMANT Mrs. Harry Irvine-Same Item #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac failure 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary arteriosclerosis DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH 15 yrs. 10 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of the Esophagus		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5-20-55 to 1-28-57 that I last saw the deceased alive on 1-27-57 , 19 57 , and that death occurred at 5:45 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 371 Conn. Ave. N.W. DATE SIGNED 1-28-57 ACTUAL SIGNATURE C. Roger Kurtz M.D. 3701 Conn. Ave. N.W., Washington, D. C. PHYSICIAN'S NAME (Type) C. Roger Kurtz, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-transit		22b. DATE THEREOF 1/30/1957	
22c. NAME OF CEMETERY OR CREMATORY Memorial		22d. LOCATION (City, town, or county) (State) Warwick Co., Va. Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-7557 Wis. Ave. Bethesda Md		24a. REC'D BY REGISTRAR DATE 1-24-57	
24b. REGISTRAR'S SIGNATURE Deane McCompton			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

Name of Deceased		John J. O'Connell	
Sex		Male	
Age		41 Years	
Date of Birth		1902	
Place of Birth		Brooklyn, N.Y.	
Date of Death		January 11, 1957	
Time of Death		11:00 A.M.	
Cause of Death		Heart Disease	
Place of Death		Home	
Signature of Physician		[Signature]	
Signature of Registrar		[Signature]	
Date of Registration		January 11, 1957	
Place of Registration		Baltimore, Md.	

BUREAU V. 3

JAN 31 1957

RECEIVED

1-30-1957

1-30-1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 9 FilmG209 1-23-57 et

00900

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Echo		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Glen Echo	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6826 Waukesha Rd.		d. STREET ADDRESS 6826 Waukesha Rd.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Agnes Middle Stewart Last Stewart		4. DATE OF DEATH Month Jan. Day 11, Year 1957	
5. SEX female	6. COLOR OR RACE col	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 23, 1892
9. AGE (In years last birthday) 65 6/12 yrs.		10. IF UNDER 1 YEAR Months 6 Days 12 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house wife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Mose Hopkins		14. MOTHER'S MAIDEN NAME Charlotte Kinslow	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Lillian Hart		Address 6826 Waukesha Road., Glen Echo, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 330x Cerebral Vascular Accident DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO Interval between onset and death Found dead in bed			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) History of previous C.V.A.			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/26/57	
22c. NAME OF CEMETERY OR CREMATORY Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Suitland, Md. C.	
23. FUNERAL DIRECTOR'S SIGNATURE W. Ernest Jarvis Co.		24a. REC'D BY REGISTRAR JAN 28 1957	
ADDRESS 1432 You ST. N.W.		24b. REGISTRAR'S SIGNATURE Bessie Thompson	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the registrar. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

909

CERTIFICATE OF DEATH

00901

Reg. Dist. No. 274

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring, Md.</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>10,011 GEORGIA AVENUE</u>				d. STREET ADDRESS <u>10,011 Georgia ave</u>					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Middle Last <u>Julia Ann Stout</u>				4. DATE OF DEATH Month Day Year <u>January 31 1957</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 22, 1956</u>			
9. AGE (In years last birthday) yrs. <u>3</u>		IF UNDER 1 YEAR Months <u>3</u> Days <u>9</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY					
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>					
13. FATHER'S NAME <u>Henry W. Stout</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Anna McMahon</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.					
17. INFORMANT <u>Henry W. Stout</u>				Address <u>10,011 Georgia Ave. Silver Spring, Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO <u>600.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bilateral pneumonia</u> DUE TO (c) <u>Pyelonephritis -</u>								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)									
21. I certify that I attended the deceased from <u>10/22</u> , 19 <u>56</u> , to <u>1/24</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1/24</u> , 19 <u>57</u> , and that death occurred at <u>M.</u> , from the causes and on the date stated above.									
ACTUAL SIGNATURE <u>Herbert D. Glick</u> M.D.				ADDRESS (Street, city or town, state) <u>8301 Pinery Branch Rd - Sil. Spr, Md</u>					
DATE SIGNED <u>1/31/57</u>									
PHYSICIAN'S NAME (Type) <u>Herbert D. Glick</u>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2/2/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ST. JOHN'S CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MD.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner C. Humphrey</u>				ADDRESS <u>SILVER SPRING, MD.</u>					
24a. REC'D BY REGISTRAR <u>1/31/57</u>				24b. REGISTRAR'S SIGNATURE <u>Frances L. L...</u>					

CERTIFICATE OF DEATH

STATE OF NEW YORK DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

NAME OF DECEASED JAMES J. JONES		SEX Male		AGE 35	
PLACE OF BIRTH New York City		DATE OF BIRTH 1922		PLACE OF DEATH New York City	
OCCUPATION Clerk		CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural	
DATE OF DEATH 1957		TIME OF DEATH 10:00 AM		PLACE OF INTERMENT St. John's Church	
SIGNATURE OF DECEASED (None)		SIGNATURE OF WITNESSES (None)		SIGNATURE OF PHYSICIAN (None)	
SIGNATURE OF CORONER (None)		SIGNATURE OF JURY (None)		SIGNATURE OF STATE ATTORNEY (None)	

BUREAU V. 5

FEB 5 1957

RECEIVED

CERTIFICATE OF DEATH

00902

Reg. Dist. No.

214

1. PLACE OF DEATH a. COUNTY <u>Montgomery Co.</u> <u>Kensington - Mont.</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>W. Hyattsville Md</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Garden San.</u>		d. STREET ADDRESS <u>5844 Jamestown Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>William Kirkpatrick Swanson</u>		4. DATE OF DEATH Month <u>1</u> - Day <u>22</u> - Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 19, '78</u>
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Carpenter</u>	
11. BIRTHPLACE (State or foreign country) <u>Georgia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William E. Swanson</u>		14. MOTHER'S MAIDEN NAME <u>Sarah O'donnell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>yes</u> <u>4-11-01</u> <u>4-11-04</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Robert Swanson</u>		Address <u>Hyatt, Md.</u> <u>5844 Jamestown R.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis Generalized</u> (c) <u>Senility</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>yr.</u> <u>yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 25, 1956</u> to <u>Jan. 22, 1957</u> that I last saw the deceased alive on <u>11/17/57</u> , 19 <u> </u> , and that death occurred at <u>6:45 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Samuel Allen M.D.</u> M.D.		ADDRESS (Street, city or town, state) <u>Kensington, Md</u>	
PHYSICIAN'S NAME (Type) <u>Samuel Allen M.D.</u>		DATE SIGNED <u>1/22/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	22b. DATE THEREOF <u>1-25-1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	22d. LOCATION (City, town, or county) (State) <u>Arlington</u> <u>Va.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W W Neal Funeral Home</u>		ADDRESS <u>4812 Georgia Ave N.W.</u>	
24a. REC'D BY REGISTRAR <u>25 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Frances Potley</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

JAN 23 1957

RECEIVED
JAN 25 1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

911

CERTIFICATE OF DEATH

00903

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			
c. LENGTH OF STAY IN 1b <u>9-4 pm</u>				d. STREET ADDRESS <u>4612 Chase Ave.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Baby Girl</u> First Middle Last <u>THOMPSON</u>				4. DATE OF DEATH <u>1-22-57</u> Month Day Year			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-22-57</u>	
9. AGE (In years last birthday) <u>6 mos.</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Infant</u>		11. BIRTHPLACE (State or foreign country) <u>Bethesda, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Thompson, Sidney SR.</u>		14. MOTHER'S MAIDEN NAME <u>Stone Street, Virginia</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Thompson, MR Sidney SR.</u> Address <u>4612 Chase Ave. Beth.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>761.5</u> DUE TO <u>Atelectasis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Prematurity</u> (c) <u>Placenta Previa, Central type</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Jan 22</u> , 19 <u>57</u> , to <u>Jan 22</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Jan 22</u> , 19 <u>57</u> , and that death occurred at <u>5:05 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Michael L. Buckley</u> M.D.				ADDRESS (Street, city or town, state) <u>4630 Montgomery Ave Bethesda Md.</u>			
PHYSICIAN'S NAME (Type) <u>Michael L. Buckley, M.D.</u>				DATE SIGNED <u>1-23-57</u>			
22a. BURIAL CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>Jan 24-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Monocacy Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Poolesville Montg. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Md.</u>				24a. REC'D BY REGISTRAR <u>1-23-57</u>		24b. REGISTRAR'S SIGNATURE <u>Dennis M. Humphreys</u>	

2074285XVO

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

THOMPSON

Baltimore, Maryland

BUREAU V. E.

JAN 25 1957

RECEIVED

THIS IS A PUBLIC RECORD. It is the property of the State of Maryland and is loaned to you for your use only. It is not to be reproduced, in whole or in part, without the written consent of the State Department of Health. The State Department of Health is not responsible for the accuracy of the information furnished by you. The State Department of Health is not responsible for the accuracy of the information furnished by you. The State Department of Health is not responsible for the accuracy of the information furnished by you.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00904

912

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WEST VIRGINIA b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c. LENGTH OF STAY IN 1b 3 months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 207 E. SCHUYLER ROAD				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) JOHN First J. Middle TOBIAS Last				4. DATE OF DEATH JAN. Month 16 Day 19 Year 57			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH OCT. 15, 1887	
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) COAL MINER				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BUDAPEST HUNGARY	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME JOHN TOBIAS				14. MOTHER'S MAIDEN NAME JULIA VASVARY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 235-09-0233		17. INFORMANT MRS. ELIZABETH STEIN, 207 E. Schuyler Road Silver Spring, Md. Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF STOMACH 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 1 YEAR			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) SILVER SPRING, MD.				20g. (County) MONTGOMERY COUNTY, MD.		20h. (State) MD.	
21. I certify that I attended the deceased from OCT. 1-15 , 19 57 , to 1-16 , 19 57 , that I last saw the deceased alive on 1-15 , 19 57 , and that death occurred at 3 A. M., from the causes and on the date stated above.							
ACTUAL SIGNATURE L. B. SNOW				ADDRESS (Street, city or town, state) 9013 Flower Ave. SILVER SPRING, MD.			
PHYSICIAN'S NAME (Type) L. B. SNOW				DATE SIGNED 1/16/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1/19/57		22c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN CEMETERY		22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Warner G. Pumphrey				ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR 1-17-57	
				24b. REGISTRAR'S SIGNATURE Frances Potter			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

913

CERTIFICATE OF DEATH

00905

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Chesapeake			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 10 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				d. STREET ADDRESS 4530 32nd Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Frank Lynn TRACY				4. DATE OF DEATH Month January Day 22 Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 14 June 1887		9. AGE (In years last birthday) yrs. 69	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Marine Corps				10b. KIND OF BUSINESS OR INDUSTRY U.S. MarCor (Retired)		11. BIRTHPLACE (State or foreign country) New Jersey	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME Frank TRACY				14. MOTHER'S MAIDEN NAME Angeline BEEMAN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		(If yes, give war or dates of service) WW-I		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Official Navy Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH 15 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. ft. p. m. Month, Day, Year 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) U.S. Naval Hospital, Bethesda, Md.	
20f. (City or town) Washington, D. C.				20g. (County) District of Columbia		20h. (State) District of Columbia	
21. I certify that I attended the deceased from 12 January , 19 57 , to 22 January , 19 57 , that I last saw the deceased alive on 21 January , 19 57 , and that death occurred at 02:45 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 1-22-57							
ACTUAL SIGNATURE R.G. Williams				PHYSICIAN'S NAME (Type) R.G. WILLIAMS, CDR, MC, USN			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 1-25-57		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	
22d. LOCATION (City, town, or county) Washington, D. C.				22e. (State) District of Columbia			
23. FUNERAL DIRECTOR'S SIGNATURE S.H. Hines				23a. REC'D BY REGISTRAR 1-22-57		23b. REGISTRAR'S SIGNATURE Bary B. Parrelly	

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
JAMES H. HARRIS		Male		65		1890	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
1000 N. E. Street		Retired		Heart Disease		Natural	
DATE OF DEATH		PLACE OF DEATH		CERTIFICATE OF DEATH		MANNER OF DEATH	
Jan 24 1957		Home		U.S. Public Health Service		Natural	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES	
[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. S.

JAN 24 1957

RECEIVED

CERTIFICATE OF DEATH

00906

Reg. Dist. No. 214

914

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 24 yrs.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 SILVER SPRING			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9318 Sudbury Road		d. STREET ADDRESS 9318 Sudbury Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First RUTH Middle C. Last TUNIS		4. DATE OF DEATH Month JAN. Day 12 Year 19 57	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT. 15, 1898
9. AGE (In years last birthday) yrs. 58		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) DETROIT, MICHIGAN		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JESSE STOUT CHIPMAN		14. MOTHER'S MAIDEN NAME MARY LOUISE CASWELL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Mr. Henry M. Tunis, 9318 Sudbury Road		Address Silver Spring, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis, abdominal 153X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma, colon (recto-sigmoid) DUE TO (c) 24 yrs. INTERVAL BETWEEN ONSET AND DEATH 1 yr.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 19 36 to Jan. 12, 19 57 , that I last saw the deceased alive on Jan. 8, 19 57 , and that death occurred at 3 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 10,620 So. Ave., Silver Spr., Md. DATE SIGNED ACTUAL SIGNATURE Philip H. Varner PHYSICIAN'S NAME (Type) PHILIP H. VARNER			
22a. BURIAL, CREMATION, REMOVAL (Specify) ENTOMBMENT		22b. DATE THEREOF 1/15/57	
22c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEMETERY		22d. LOCATION (City, town, or county) (State) PRINCE GEORGE COUNTY, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey		24a. REC'D BY REGISTRAR DATE 1/17/57	
24b. REGISTRAR'S SIGNATURE Frances Potter			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text]		SEX [Faint text]		AGE [Faint text]	
DATE OF DEATH [Faint text]		PLACE OF DEATH [Faint text]		CITY [Faint text]	
TIME OF DEATH [Faint text]		CAUSE OF DEATH [Faint text]		MANNER OF DEATH [Faint text]	
PLACE OF BIRTH [Faint text]		DATE OF BIRTH [Faint text]		SEX [Faint text]	
OCCUPATION [Faint text]		EDUCATION [Faint text]		RELIGION [Faint text]	
MARITAL STATUS [Faint text]		PREVIOUS MARRIAGES [Faint text]		PREVIOUS DEATHS [Faint text]	
SIGNATURE OF DECEASED [Faint text]		SIGNATURE OF WITNESS [Faint text]		SIGNATURE OF PHYSICIAN [Faint text]	
SIGNATURE OF CORONER [Faint text]		SIGNATURE OF JURY [Faint text]		SIGNATURE OF JUDGE [Faint text]	
SIGNATURE OF CLERK [Faint text]		SIGNATURE OF REGISTRAR [Faint text]		SIGNATURE OF ARCHIVIST [Faint text]	

BUREAU V. S.

JAN 21 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death: Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

915

CERTIFICATE OF DEATH

00907

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington 47X-3</u>	
c. LENGTH OF STAY IN 1b <u>6 1/2 hrs.</u>		d. STREET ADDRESS <u>3342 Shepherd Place N.W.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Victoria Briggs TURNER</u>		4. DATE OF DEATH Month Day Year <u>1 - 9 1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-29-73</u>
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Examiner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Government</u>	
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>George A. Briggs</u>		14. MOTHER'S MAIDEN NAME <u>Helen M. Baker</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Jessie Knowles (reice) 140 Locust ST. Rockport New York</u>	
17. INFORMANT Address <u>Jessie Knowles (reice) 140 Locust ST. Rockport New York</u>		18. INTERVAL BETWEEN ONSET AND DEATH <u>14 hours</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Sclerosis</u> DUE TO (c) <u>Generalised arteriosclerosis</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Left cerebral embolism with aphasia</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1.9.1957</u> to <u>5/1.9.1957</u> , that I last saw the deceased alive on <u>1.9.1957</u> , and that death occurred at <u>2:25 P.M.</u> from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) <u>3921 Engeman St N.W. Wash D.C.</u>		DATE SIGNED <u>1.9.57</u>	
ACTUAL SIGNATURE <u>Stewart Clapp</u> M.D.		DATE SIGNED <u>1.9.57</u>	
PHYSICIAN'S NAME (Type) <u>Stewart Clapp</u>		DATE SIGNED <u>1.9.57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/12/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Prospect Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Front Royal, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u>		24a. REC'D BY REGISTRAR <u>1-10-57</u>	
24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>			

CERTIFICATE OF DEATH

Page No. 10

Name of Deceased		Age		Sex		Race		Religion		Marital Status		Occupation		Education		Date of Birth		Date of Death		Place of Birth		Place of Death	
John Doe		45		Male		White		Catholic		Single		Teacher		High School		1910		1955		New York		New York	
Cause of Death		Disease		Symptoms		Duration		Treatment		Result		Autopsy		Burial		Funeral		Interment		Cremation		Other	
Heart Disease		Myocardial Infarction		Chest Pain		2 Weeks		Medicine		Death		Yes		Buried		Funeral Home		Catholic Church		No		No	

BUREAU V. S.

JAN 15 1957

RECEIVED

U H I I

M.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

00908
773

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>D.C.</u> b. COUNTY <u>Washington, N.W.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, N.W.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium Hospital</u>		d. STREET ADDRESS <u>1914 Con necticut Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Kathryn Freleigh Underhill</u>		4. DATE OF DEATH <u>January 28</u> 1957	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 9, 1880</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wesley Freleigh</u>		14. MOTHER'S MAIDEN NAME <u>Helen Stowe</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of the lung</u> 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>6 months</u> (c) <u>Interval between onset and death</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Sept 1</u> , 19 <u>56</u> to <u>Jan 28</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Jan 28</u> , 19 <u>57</u> , and that death occurred at <u>11:45 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edward Adelson</u>		ADDRESS (Street, city or town, state) <u>1302 18th St N.W., Wash, D.C.</u>	
PHYSICIAN'S NAME (Type) <u>Edward Adelson</u>		DATE SIGNED <u>1/29/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1/31/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Suitland, Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers & Co, Wash, D.C.</u>		24. REC'D BY REGISTRAR <u>Jan 31 1957</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>J. Nelson Adley</u>	

CERTIFICATE OF DEATH

BUREAU V. S.

JAN 31 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00909

916

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE District of Columbia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		d. STREET ADDRESS 1701 20th St., N.W.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Grace Middle Beryl Last VESTAL		4. DATE OF DEATH Month January Day 26 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 22 Jan. 1888
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy (Retired)	
11. BIRTHPLACE (State or foreign country) Arkansas		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Vincent Vestal		14. MOTHER'S MAIDEN NAME Nanne Pride	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 11-26-21 to 1-7-44 (Unknown)	
17. INFORMANT Official Navy Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lymphosarcoma 200.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 10 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 20 May , 19 56 , to 26 Jan. , 19 57 , that I last saw the deceased alive on 26 Jan. , 19 57 , and that death occurred at 2:40 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE W.D. Hooper		ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 1-28-57	
PHYSICIAN'S NAME (Type) W.D. HOOVER, LT, MC, USN		U.S. Naval Hospital, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-30-57	
22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey		ADDRESS 7557 Wisconsin Ave, Bethesda, Md.	
24a. REC'D BY REGISTRAR 1-28-57		24b. REGISTRAR'S SIGNATURE Marjorie E. Parrelly	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
JAMES H. HARRIS		65		M		W		JAN 29 1957		BALTIMORE, MD.	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE NO.		REGISTRATION NO.	
1000 E. BALTIMORE ST.		RETIRED		HEART DISEASE		NATURAL		1000		1000	
DATE OF BIRTH		PLACE OF BIRTH		EDUCATION		MARRIAGE		SIGNED		NOTED	
JAN 29 1957		BALTIMORE, MD.		HIGH SCHOOL		MARRIED		JAN 29 1957		JAN 29 1957	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE NO.		REGISTRATION NO.	
JAN 29 1957		BALTIMORE, MD.		HEART DISEASE		NATURAL		1000		1000	

BUREAU V. 2

JAN 29 1957

RECEIVED

792

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 26 Rockville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 301 N. Adams Street				d. STREET ADDRESS 301 N. Adams Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Benjamin nmi WEISS				4. DATE OF DEATH Month Day Year January 18 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 27, 1895		9. AGE (In years last birthday) yrs. 61	IF UNDER 1 YEAR Months Days Hours Min. 9 21	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Operating Engineer		10b. KIND OF BUSINESS OR INDUSTRY Nat. Inst. Health		11. BIRTHPLACE (State or foreign country) New York City		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) W. W. I		16. SOCIAL SECURITY NO. 087-16-4245		17. INFORMANT Address Clinical Center Records-Bethesda, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Occlusion DUE TO (c) Previous coronary thrombosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 5-10 min 5-10 min 2 mos.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from May 1958 to 1-18 1957 , that I last saw the deceased alive on 1-17 1957 , and that death occurred at 4:30 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE W. G. Hall M.D.				ADDRESS (Street, city or town, state) 615 W. Montgomery Ave. Rockville, Md.			
DATE SIGNED 1/18/57							
PHYSICIAN'S NAME (Type) W. G. Hall, M.D.				615 W. Montgomery Ave. Rockville, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/22/1957		22c. NAME OF CEMETERY OR CREMATORY Parklawn		22d. LOCATION (City, town, or county) (State) Rockville Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-7557 Wis. Ave. Beth. Md.				ADDRESS 7557 Wis. Ave. Beth. Md.		24a. REC'D BY REGISTRAR 1/22/57	
24b. REGISTRAR'S SIGNATURE Spurrell Kragtorp							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

COVILLO

COVILLO

COVILLO

COVILLO

COVILLO

COVILLO

COVILLO

COVILLO

COVILLO

COVILLO

COVILLO

COVILLO

COVILLO

COVILLO

COVILLO

COVILLO

COVILLO

COVILLO

COVILLO

COVILLO

COVILLO

COVILLO

BUREAU V. S.

JAN 24 1957

RECEIVED

COVILLO

COVILLO

COVILLO

COVILLO

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00912

918

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 50 minutes		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 47x-3 Washington			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Maryland				d. STREET ADDRESS 1010 14th Street, S.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last George Hubert WHEELER				4. DATE OF DEATH Month Day Year January 20 19 57			
5. SEX Male	6. COLOR OR RACE Cauc.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-26-86		9. AGE (In years lost birthday) yrs. 70	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy (Retired)		11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Fred Wheeler				14. MOTHER'S MAIDEN NAME Isabella Aubinoe			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes WW-I&II		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address (Brother) James H. Murphy (Same As #2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 1 hr.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 20 January, 19 57 to 20 January, 19 57 , that I last saw the deceased alive on 20 January, 19 57 , and that death occurred at 2:35 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Wiley R. Smith U.S. Naval Hospital, Bethesda, Md. 1-21-57 ACTUAL SIGNATURE M.D. PHYSICIAN'S NAME (Type) Wiley R. Smith, LT, MC, USN U.S. Naval Hospital, Bethesda, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 24 Jan. 1957		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Chambers ADDRESS 517 11th St., S.E. Washington, D. C.				24a. REC'D BY REGISTRAR DATE 1-21-57		24b. REGISTRAR'S SIGNATURE Wiley R. Smith	

CERTIFICATE OF DEATH

U.S. BUREAU V. S.

JAN 24 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

919

CERTIFICATE OF DEATH

00913

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY, MD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Washington, D.C.</u> b. COUNTY <u>Washington, D.C.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Suburban Hosp.</u>				c. LENGTH OF STAY IN 1b <u>10 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hosp.</u>				d. STREET ADDRESS <u>1811-Upshur St., N.W.</u>			
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Mayo</u> Last <u>Wills</u>				4. DATE OF DEATH Month <u>January</u> Day <u>17</u> Year <u>1957</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-1-82</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer - Ordnance</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Naval Gun Factory</u>		11. BIRTHPLACE (State or foreign country) <u>Chatham, VA.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Robert Wills</u> MOTHER'S MAIDEN NAME <u>Sublet</u>			
14. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>-</u>				15. SOCIAL SECURITY NO. <u>No</u>			
16. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> <u>260x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> (c) <u>Diabetes mellitus</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1+ week</u> <u>10+ years</u> <u>30+ years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Prostatitis & cystitis</u>							
17. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				18. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
19a. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.				19b. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
19c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				19d. (City or town) (County) (State)			
20. I certify that I attended the deceased from <u>Oct</u> , 19 <u>57</u> , to <u>Jan</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>11/17</u> , 19 <u>57</u> , and that death occurred at <u>7:00 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Charles Savarese, Jr.</u> M.D. <u>4861 Battery Lane</u>				DATE SIGNED <u>11/17/57</u>			
PHYSICIAN'S NAME (Type) <u>CHARLES J. SAVARESE, JR.</u> <u>Bethesda, Md.</u>							
21a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		21b. DATE THEREOF <u>1/21/1957</u>		21c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		21d. LOCATION (City, town, or county) (State) <u>Prince Georges County, Md.</u>	
22. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.</u> ADDRESS <u>2901 14th St., N.W.</u> <u>Washington, D.C.</u>				23. REC'D BY REGISTRAR <u>DATE 1-21-57</u>			
24. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>							

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
WILLIAM W. WILSON		MALE		40		1-1-1885		BALTIMORE, MARYLAND	
MARRIAGE		DATE OF MARRIAGE		PLACE OF MARRIAGE		NAME OF SPouse		DATE OF DEATH	
MARRIED		1-1-1910		BALTIMORE, MARYLAND		JANE W. WILSON		1-1-1957	
CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH		DATE OF DEATH		TIME OF DEATH	
HEART DISEASE		NATURAL		BALTIMORE, MARYLAND		1-1-1957		10:00 AM	
SIGNS AND SYMPTOMS		HISTORY		PHYSICIAN'S NAME		HOSPITAL NAME		HOSPITAL ADDRESS	
PAIN IN CHEST, SHORTNESS OF BREATH		WAS ADMITTED TO HOSPITAL 12-15-56		DR. J. H. SMITH		BALTIMORE HOSPITAL		1000 N. CALVERT ST.	
TREATMENT		PREVIOUS ILLNESS		PREVIOUS SURGERY		PREVIOUS TRAUMA		PREVIOUS DRUGS	
NONE		NONE		NONE		NONE		NONE	
FAMILY HISTORY		SOCIAL HISTORY		OCCUPATION		EDUCATION		RELIGION	
NONE		NONE		NONE		NONE		NONE	
FAMILY HISTORY		SOCIAL HISTORY		OCCUPATION		EDUCATION		RELIGION	
NONE		NONE		NONE		NONE		NONE	

BUREAU V. S.

JAN 23 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

920

Item 14 Film G209 1-18-57 et

CERTIFICATE OF DEATH

00914

Reg. Dist. No. 216

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		d. STREET ADDRESS <u>14629 Rose Dale Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>WIRZSEK</u> Last <u>WIRZSEK</u>		4. DATE OF DEATH Month <u>Jan.</u> Day <u>9</u> Year <u>1957</u>	
5. SEX <u>7</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/29/85</u>
9. AGE (In years last birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Austria-Hungary</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>KOBILOBSKY</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia, lobar</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral vascular accident</u> DUE TO (c) <u>Hypertension & arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>9 days</u> <u>10 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1 Jan.</u> , 1957, to <u>9 Jan.</u> , 1957, that I last saw the deceased alive on <u>9 January</u> , 1957, and that death occurred at <u>10:10 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>7659 Georgetown Rd.</u> DATE SIGNED <u>9 Jan 57</u>			
ACTUAL SIGNATURE <u>John M. Wynn</u>		M.D. <u>7659 Georgetown Rd.</u>	
PHYSICIAN'S NAME (Type) <u>Bethesda 14, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Jan. 10, 1957</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Ives Funeral Home</u>		22d. LOCATION (City, town, or county) (State) <u>Orlinton, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ives Funeral Home - Byrd S. B. Orlinton</u>		ADDRESS <u>DATE - 10 - 57</u>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

BUREAU V. S.

JAN 14 1957

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00915

921

CERTIFICATE OF DEATH

Reg. Dist. No. 211

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Montgomery</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dickerson RFD #1</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dickerson, R.F.D. #1</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION -				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Cora</u> Middle <u>B.</u> Last <u>Wood</u>				4. DATE OF DEATH Month <u>Jan.</u> Day <u>29</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 27, 1873</u>	
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <u>Maryville, Tenn.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Frank H. Thomas</u>				14. MOTHER'S MAIDEN NAME <u>Bethaney Dennis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. -		17. INFORMANT <u>Glenn Z. Wood - 9810 Georgia Ave Silver Spring Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL THROMBOSIS</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIAL HYPERTENSION</u> DUE TO (c) <u>ARTERIOSCLEROSIS</u> INTERVAL BETWEEN ONSET AND DEATH <u>TEN DAYS</u> <u>15 YEARS</u> <u>20 YEARS</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CONGESTIVE HEART FAILURE</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>July 22, 1955</u> to <u>JANUARY 29, 1957</u> , that I last saw the deceased alive on <u>JANUARY 27, 1957</u> , and that death occurred at <u>2 P.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>26 N. Summit Ave.</u> DATE SIGNED <u>29 Jan 1957</u> ACTUAL SIGNATURE <u>Gordon S. Rosenberger</u> M.D. PHYSICIAN'S NAME (Type) <u>Gordon S. Rosenberger</u> <u>Gaithersburg, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2-1-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Forest Oak Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Gaithersburg, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ernest C. Garton Gaithersburg Md.</u>				24a. REC'D BY REGISTRAR DATE <u>Feb 1, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Della W. Burdett</u>	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00916

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE W D.C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA (Rural)				c. LENGTH OF STAY IN 1b 4 DAYS			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U.S. NAVAL HOSPITAL, Bethesda, Md.				e. STREET ADDRESS 4000 CATHEDRAL AVE N.W.			
3. NAME OF DECEASED (Type or print) CHARLOTTE L. WOODWARD				4. DATE OF DEATH JANUARY 18 19 57			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JANUARY 6 1889		9. AGE (In years last birthday) 68 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) CAL.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME CARL C. LINNE				14. MOTHER'S MAIDEN NAME KATHLEEN OREILLY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT HOSPITAL RECORDS Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SHOCK 916.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 1st 2nd 3rd DEGREE BURNS INVOLVING ABOUT 70 % (c) OF BODY							INTERVAL BETWEEN ONSET AND DEATH 10 DAYS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) DRESSING GOWN CAUGHT FIRE AT HOME					
20c. TIME OF INJURY Month, Day, Year 1-8 19 57 Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) HOME		20f. (City or town) (County) (State) WASHINGTON D.C.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>Frank J. Broschart</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) FRANK J. BROSCART				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 1-18-57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-23-57		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph GAWLER'S & SONS				ADDRESS 1756 Penna. Ave. N.W. Washington D.C.		24a. REC'D BY REGISTRAR DATE 1-19-57 24b. REGISTRAR'S SIGNATURE <i>May L. Carrelly</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the files. TO THE FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

PHYSICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

JAN 23 1957

RECEIVED

785

CERTIFICATE OF DEATH

Reg. Dist. No.

220

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Tikoma PK</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium-Hospital</u>		d. STREET ADDRESS <u>8716 Colesville Rd. Apt. 302</u> IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Robert Nutte Woolard</u>		4. DATE OF DEATH Month <u>1</u> Day <u>31</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Ca</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-7-71</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Grocery</u>	9. AGE (In years last birthday) <u>85</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>Am.</u>	
13. FATHER'S NAME <u>Thomas Woolard</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Bell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>577-05-8279-A</u>	
17. INFORMANT <u>Hospital record</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of Bladder - extensive</u> 181x DUE TO (b) <u>metastasis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Terminal Uremia</u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 wks 2 mos</u> <u>3 wks.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Advanced arteriosclerosis</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May 10, 1948</u> , to <u>Jan 31, 1957</u> , that I last saw the deceased alive on <u>Jan 31, 1957</u> , and that death occurred at <u>9 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Kenneth F. Laughlin</u> M.D.		ADDRESS (Street, city or town, state) <u>934 Ellsworth Dr. Silver Spring Md</u> DATE SIGNED <u>1-31-57</u>	
PHYSICIAN'S NAME (Type) <u>KENNETH F. LAUGHLIN</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>ENTOMBMENT</u>	22b. DATE THEREOF <u>2/4/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>PRINCE GEORGE COUNTY, MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles E. Humphreys</u> ADDRESS <u>8434 Georgia Ave. Silver Spring Md.</u>		24a. REC'D BY REGISTRAR DATE <u>2-2-57</u>	24b. REGISTRAR'S SIGNATURE <u>J. Nelson Dodd</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 3 and 4 should be filed with the funeral director.

CERTIFICATE OF DEATH

Reg. No. 40

1. Name of deceased		2. Sex		3. Age		4. Race		5. Date of death		6. Time of death		7. Place of death		8. Cause of death		9. Manner of death		10. Signature of physician		11. Signature of registrar		12. Signature of informant	

923

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 47x3 Washington			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Maryland				d. STREET ADDRESS 5400 32nd St., N.W.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First Ray Middle Frederick Last YAGER		4. DATE OF DEATH Month January Day 7 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 24 October 1899		9. AGE (In years last birthday) yrs. 57	10. IF UNDER 1 YEAR: Months 7 Days 7 Hours 19 Min. 57	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy		11. BIRTHPLACE (State or foreign country) Kentucky		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Joel W. Yager				14. MOTHER'S MAIDEN NAME Estella Stucy			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. 2-20-35tol-7-57 400-54-2179		17. INFORMANT Mrs. Alice E. Yager (Same As #2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 162x Bronchogenic Carcinoma metastasis DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH 1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from 15 Aug. , 19 56 , to 7 Jan. , 19 57 , that I last saw the deceased alive on 7 Jan. , 19 57 , and that death occurred at 11:00P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 1-8-57							
ACTUAL SIGNATURE R. J. McCarthy		M.D. U.S. Naval Hospital, Bethesda, Md. 1-8-57					
PHYSICIAN'S NAME (Type) R. J. MC CARTHY, CDR, MC, USN		U.S. Naval Hospital, Bethesda, Md. 1-8-57					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-11-57		22c. NAME OF CEMETERY OR CREMATORY ODD Fellows Cemetery		22d. LOCATION (City, town, or county) (State) Carrollton, Kentucky	
23. FUNERAL DIRECTOR'S SIGNATURE R. A. PUMPHREY, 7557 Wisconsin Ave., Bethesda, Md.				24a. REC'D BY REGISTRAR DATE 1-8-57		24b. REGISTRAR'S SIGNATURE Ray C. Russell	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
John (Name)		Male		25	
Date of Death		Place of Death		Cause of Death	
Jan 10, 1957		Baltimore, Maryland		Heart Disease	
Time of Death		Place of Burial		Name of Minister	
10:00 AM		St. Paul's Church		Rev. J. Smith	
Signature of Physician		Signature of Registrar		Signature of Coroner	
[Signature]		[Signature]		[Signature]	
Date of Certificate		Place of Issuance		Name of Issuer	
Jan 10, 1957		Baltimore, Maryland		John V. S.	

BUREAU V. S.

JAN 10 1957

RECEIVED

TO BE RELAINED BY THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

924

Item 9 Film G209 1-21-57 et

CERTIFICATE OF DEATH

Reg. Dist. No.

00919

216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>	
c. LENGTH OF STAY IN 1b <u>55 years</u>		d. STREET ADDRESS <u>110314 Fawcett St.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>10314 Fawcett St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Martha</u> Middle <u>M</u> Last <u>Zimmerman</u>		4. DATE OF DEATH Month <u>JAN</u> Day <u>10</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>? Approx. ? 82</u> yrs.
9. AGE (In years last birthday) <u>? 82</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Catskill N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mr. R.F. Green - Kensington Md.</u>		Address <u>Kensington Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma</u> <u>170X</u> DUE TO <u>Carcinoma of left breast</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>4000</u> (b) <u>—</u> (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Heart Disease</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10/30/53</u> , 19____, to <u>1/10/57</u> , 19____, that I last saw the deceased alive on <u>Jan 9</u> , 19 <u>57</u> , and that death occurred at <u>7:50</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Marion Benzhead</u> M.D.		ADDRESS (Street, city or town, state) <u>9241 Col. Blvd.</u> DATE SIGNED <u>1/10/57</u>	
PHYSICIAN'S NAME (Type) <u>J. Marion Bank Head Silver Spring Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-Transit 1/11/57</u>	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY <u>Jefferson Rural Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Green Co. New York</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>DATE 1-10-57</u> 24b. REGISTRAR'S SIGNATURE <u>Beattie M. Thompson</u>	

RECEIVED

JAN 15 1957

BUREAU V. S.

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON